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THROUGH THE MICROSCOPE

WHETHER working a crossword puzzle or scoring ourselves on a list of popular questions, all of us at times enjoy testing our ability and measuring our achievements in one way or another.

This year the National Organization for Public Health Nursing is making an unusually careful inventory of itself; what it has accomplished during the past year; where it has failed to score a perfect record; what its functions should be in relation to those of other agencies; and most important of all, how it shall plan to serve you during the coming year.

We invite you to follow suit, and to join us in making this twenty-fifth landmark in the life of the organization the occasion for a special study of the accomplishments of your own agency and its needs for the coming year.

What are some of the questions which a local organization might ask itself by way of self-appraisal as the old year gives place to the new one? We are suggesting a few here. You can supplement the list from a knowledge of your own particular situation and problems.

1 Does your agency function as a part of an entire community health program, dovetailing its work effectively with that of other health and welfare agencies and of the medical group? If you are working in the school, is your service an integral part of the entire school system, closely coördinated with the work of other departments? What actual plans and techniques for the development of better relationships with other community agencies has been worked out, such as:

a. Joint staff meetings
b. An exchange of staff members
c. Use of the social service exchange
d. Case conferences
e. A definite system for referral of patients
f. Use of councils to coördinate the work of various agencies

2 Do your records and reports present a vivid and complete picture of the work of your organization? Can they be used and do you use them for:

a. Studying the effectiveness of your service.
   (1) The functions in each service are listed in the new "Functions in Public Health Nursing" published in PUBLIC HEALTH NURSING, November 1936. How closely are you approaching them?
   (2) The vital statistics of your community are an indication of its needs for health service. How is your service related to those needs?
   (3) The appraisal forms for public health nursing constitute a method which has been developed to measure service

in relation to need.* Have you analyzed your service with the help of this outline?

b. Planning your program for the future on the basis of actual community needs as shown by this self-study.

c. Interpreting your service to the community.

3 Does the board of your agency participate in the joint planning of the nursing program for your entire community?

Is your board prepared to accept its share of responsibility for the sound development of nursing services under the Social Security Act?

a. By insisting on appointments of personnel on the basis of merit?

b. By urging the maintenance of accepted standards of service?

c. By interpreting the nursing service to the public?

d. By stimulating the development of citizens' committees in connection with public agencies?

4 What kind of a program have you for training and using volunteers—not for "busy work" but for actual community service? Has time been definitely budgeted for the preparation of volunteers for their work and the interpretation of your nursing service to them?

5 Has your agency a definite program for public information and a budget for that purpose? Is its interpretative program a year-round one? How effectively has your publicity program interpreted the service and needs of your agency to the public?

6 What has your agency done for the education of its staff:

a. To help and encourage the present staff (as well as new staff members) to meet the minimum qualifications for public health nurses outlined by the N.O.P.H.N.?

b. To develop a staff education program based on the needs and desires of the staff? (See editorial, page 3.)

c. To develop its members who are good supervisory or administrative material in preparation for supervisory positions which are now open and needing qualified nurses?

7 Are the working policies of your agency such as to attract good nurses to your community and make possible a continuous high quality of service?

a. How do your salaries compare with those of other communities with similar costs of living? Do they allow a margin for savings and vacation?

b. Do your working hours allow adequate free time for recreation, personal growth and the maintenance of good health?

c. Does your agency make provision for sick leave and preventive sick leave?

d. Has your agency considered its social responsibility for developing some plan to help provide for the old-age security of its nurses? (Public health nurses do not come under the old-age benefits of the Social Security Act.)

8 Does your agency teach by example the principles of public health?

a. Has it a plan for a periodic health examination of the staff?

b. Does it sincerely encourage nurses to take care of themselves in the early stages of illness; to stay away from contact with patients and staff when they have colds?

c. Most important of all, does it have a happy working atmosphere that puts into practice in working relationships the mental hygiene principles which it endeavors to use in families?

*Haupt, Alma C. "How to Appraise Public Health Nursing—Outline of Appraisal," PUBLIC HEALTH NURSING, October 1932, pp. 529-537.

American Public Health Association, 50 West 50th Street, New York, N. Y. Appraisal Form for Rural Health Work. Second edition, 1932.

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PREPARATION OF THE NURSE IN INDUSTRY

The first essential for a successful program of industrial nursing, according to Mary S. Gardner, is "a nurse who in addition to her knowledge of public health nursing, understands the principles and practices that govern industrial nursing."

Apart from the trial and error method of unguided experience, how may this understanding of industrial nursing be secured? This was a question frequently asked—but never satisfactorily answered—by the various participants in the panel discussion of the nursing session at the National Safety Congress.*

Doubtless part of the answer should come from public health nursing courses in the form of increased emphasis on the health and social problems of industry in the theoretical courses offered. However, a need even more important than theoretical preparation is the provision of an opportunity for every public health nursing student who is interested in entering the industrial field to have actual experience under supervision in a well organized industrial nursing service.

The difficulties of providing student practice fields for postgraduate work in industrial nursing are great, and the combined efforts of industrial nurses and course directors will be required to surmount them. Minimum standards for this type of affiliation should be developed and industry should be canvassed to find services which meet the standards. As a matter of fact, this use of industry for student experience is not without precedent. Student practice fields for other professional groups such as engineers are provided by industry, and these students become a source of supply for future personnel. It is believed that the opportunity to secure nurses trained and experienced in industrial work from which to recruit personnel would amply repay industry for the provision of student field work.

Efforts to make training for industrial nursing available for nurses who are interested in and personally adapted for this work would seem eminently worth while. Certainly special preparation and experience are necessary in order that nurses may become sufficiently well qualified to assume their true place in industry—not just as assistants in the first aid room but as builders of good will among employers, teachers of health and important factors in the program for the prevention of accidents and disease.

*See page 36 of this issue. R. H.

A STAFF EDUCATION PROGRAM IS BORN

Planning a staff education program —whether meant for two or fifteen or more nurses—can be really fun if imagination, informality, and a spirit of give-and-take enter into it.

We use the term staff education so glibly: a series of lectures—some good, some bad; a desultory series of reports of articles; a demonstration beautifully given by a supervisor with an "I'll show you" attitude. A program can be a real staff education experience only when certain conditions are satisfied: First, the need for the program should be recognized by all members of the group; second, all members should make some contribution which involves initiative on their part; and third, each member must be able to apply what she has learned, so as to make her service to her families, community and organization more productive of results and also to further her own growth.

These three conditions might be called first principles to be observed in planning an effective educational program for any group of nurses. Let us follow through the steps of a program based on these conditions.

1. Each unit of the program should be based on a recognized need—on problems recognized not just by the supervisors but by the group as a whole. Preliminary conferences will be needed to stimulate the group to analyze their thinking, to discover and crystallize their most important problems. There may be enough problems found to last for a good many months. Choices will have to be

made, concessions granted, and decisions arrived at before the most important ones can be selected. No problem suggested by a staff member should be considered so trivial as not to warrant consideration. The final selection may have to be made by a committee of the group.

"My problem," says one, "is how to help a mother who asks me what to do when three-year-old Jimmy slaps the new baby. I don't know what to tell her."

"And I," says another, "find it hard to explain to a mother what should—or should not—be done when her baby sucks its thumb."

"And I"—and so on through a whole series of problems on the mental hygiene aspects of child welfare. Here are problems recognized by the whole group, and with which they feel the need of help.

2. Then comes the question, "What shall we all do about it?" In meeting these common problems there should be participation by the whole group—our second general principle.

"We ought to know what is the latest authoritative thinking on that subject," says one. 'Where can we get it?" Suggestions come from the group regarding sources of help—magazines and books, national and state agencies, local mental hygienists, psychiatrists or pediatricians who might meet with the group. Then a program begins to evolve.

"Let's get Dr. S., the psychiatrist, to speak to us."

"Good, I have some questions right now I'd like to ask him. Why can't I do it when he meets with us?"

"I think the social worker in my district would like to hear it, too."

"And I know my friend working in the hospital would."

"Let's ask them in to help us plan it."

So a joint committee may come into being and a program is planned. If put down on paper step by step it might look like this:

A presentation of the problem by the chairman of the committee (a staff nurse).

Things we need to know in order to meet the problem.

1. Staff conference with Dr. S. speaking to the group.
2. Reports on articles or books by members of the group.

Questions we would like to ask—anybody and everybody.

How to apply the information in our own particular situations.

Actual case studies from their own records (presented by nurses and social workers).

Discussion by all.

3. Thus the third principle is recognized. Each nurse must be able to apply what she has learned—in her service to the families, the community and the organization, and in her own growth.

And so is born a staff education program where the staff nurses, guided and aided by director and supervisors, recognize their problems; plan their own programs, and participate in them with initiative and enthusiasm; and apply what they have learned, to accomplish results. How can they help but grow! V. J.

The Public Health Nurse in the Control of Syphilis and Gonorrhea

By GLADYS L. CRAIN, R.N.

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We know our readers will welcome this new series of articles by Miss Crain on the nurse's part in the program for the control of syphilis and gonorrhea. We feel that these articles are especially timely in view of the awakened public interest in this entire subject following upon Dr. Thomas Parran's widely read article on "The Next Great Plague to Go" in the *Survey Graphic* for July 1936, also reprinted in the *Readers' Digest* for July 1936. Miss Crain needs no introduction to our readers.

Part I

The Public Health Problem

AT no time in the fifty years of public health nursing growth and development has there been a dearth of challenging problems which call for vision, experimentation and pioneering. In this comparatively brief period, innumerable opportunities for service (undreamed of by the founders of the movement) have arisen, especially in disease prevention and control and the elimination of other conditions which undermine individual and family health.

Each fresh opportuity to contribute to the general well-being of the community has been met with courage and progressiveness by public health nurses, past and present; and existing programs have expanded, or a traditional focus has been changed to fit new and growing needs.

Today, the world is faced with an insistent public health problem—the eradication of syphilis and gonorrhea, two communicable diseases which are endemic in all civilized communities.

Unaccountably, the important part which nurses might play in the control of these diseases has not been recognized until recently.

The Survey of Public Health Nursing, conducted by the National Organization for Public Health Nursing as recently as 1934,[1] proves conclusively that here is a new field for pioneering, and that it is high time public health nurses began to develop programs and techniques for assisting in the control of these widespread diseases.

Up to the present time a state of inertia has been evident among professional and lay groups, due in part to deep-rooted misconceptions, prejudices and prudery. To be sure, some progress has been made toward changing attitudes, but old ideas still persist, such as: that syphilis and gonorrhea are diseases of the vicious and outcast; that problems relating to these diseases are linked with prostitution and sexual promiscuity alone; and that the victims, being moral delinquents, deserve their fate.

EXTENT OF PROBLEM

Recent estimates of the prevalence of syphilis and gonorrhea in the United States show that 1,037,000 new cases of gonorrhea and 518,000 new cases of syphilis reach medical attention annually; and that on any given day, nearly 650,000 persons with syphilis and 500,000 persons with gonorrhea are under treatment or observation. These figures do not take into account the large numbers of unreported, unrecognized and self-treated cases. It has also been estimated that nearly fifty per cent of the cases which constitute this vast problem are patients who are innocently infected.

Interesting studies have been made comparing syphilis with other communicable diseases. These have recently been summarized by Dr. Nels A. Nelson, of the Massachusetts State Department of Health, as follows: "Syphilis is at least twice as prevalent as tuberculosis, and six times as common as diphtheria, typhoid fever and smallpox combined,"[2] and "apparently no communicable diseases, except the common cold, measles, and chickenpox outrank gonorrhea."[3]

These figures alone indicate that syphilis and gonorrhea are important health problems. But when statistics are studied in terms of age-groups, the situation becomes even more impressive. Syphilis and gonorrhea are primarily diseases of youth, for three out of every four new infections which come to medical attention are among young people between the ages of 15 and 30 years; and two per cent of all the children in this country have congenital syphilis, an entirely preventable disease.

SYPHILIS A CAUSE OF DEATH

Syphilis not only attacks youth, but is a leading cause of death—a fact which is not revealed by a superficial study of mortality statistics. Syphilis is a disease which veils its real nature under many confusing symptoms. Deaths, recorded under such causes as angina pectoris, apoplexy, nephritis and congenital debility, may be due to the spirochæta pallida. Also, physicians hesitate to put syphilis as a cause on death certificates (common property of the local undertaker and local officials too numerous to mention) for it is feared that, because of the stigma which is attached to this disease, a slur may be cast upon the character of the deceased and his relatives may be humiliated.

An example of the inaccuracy of statistics which results from the inhibiting effect of this universal prejudice is an unofficial survey made in Westchester County, New York, of all recorded deaths for the years 1931 to 1933. Additional data, secured confidentially through personal visits to each physician who made a report during this time, disclosed a final death rate for syphilis which approximately doubled the original mortality figures for this disease.

Deaths from infantile paralysis cause grave concern to entire communities and hold front-page interest in all local newspapers. Yet an analysis of statistics in Massachusetts for a five-year period revealed that there were 575 deaths from syphilis among children under fifteen years of age, and during the same period, 480 deaths from infantile paralysis. Every effort is being made, and rightly, to control the latter; but because syphilis kills case by case with no epidemic flare-ups and no publicity, the importance of concerted action against its continued spread is only just beginning to be appreciated.

Gonorrhea although not an important cause of death, has been frequently termed a preventer of life, for much of the sterility in both men and women is due to this disease. It is also responsible for a majority of gynecological operations, for invalidism in women, for crippling arthritis, for blindness, and for an imposing list of other ills which cannot be taken up at this time.

To quote Dr. P. S. Pelouze: "It would seem that, by the sheer weight of the misery it produces throughout the world, gonorrhea would force itself upon public notice." Yet gonorrhea remains the neglected "stepchild of medicine."[4]

ECONOMIC AND SOCIAL COST

The economic and social cost of syphilis and gonorrhea can hardly be reckoned. Millions of dollars are spent each year to care for the insane, the crippled, or the otherwise incapacitated. Syphilis cuts life expectancy in half, and the death of the bread-winner may mean broken homes and dependent children.

One of the chief deterrents to developing an intelligent plan for the control of syphilis and gonorrhea has been the confused thinking which mixes morals and medicine. The way out of this vexatious predicament, according to Dr. Haven Emerson, is "a direct medical and sanitary attack (upon the problem),

so reasonable, so logical, and so sustained as to arouse the public in support, and to challenge today's society to a courageous consideration of human values. . . . . What has been accomplished in control of other communicable diseases by determined use of medical knowledge can and must be done with syphilis . . . ."[5]

An outstanding example of such a direct medical attack is described in Dr. Einar Rietz's report of the magnificent progress made in the control of syphilis in Sweden. In 1919 that country, with a population of 6,000,000 inhabitants, had an average of 6000 new cases of syphilis each year. In 1934, this number dropped to 400, with the probability that the trend downward will continue. The problem has decreased to less than one tenth of what it was fifteen years ago.

PROGRAM FOR CONTROL

It is evident from a study of the program in Sweden, that there is no magic formula for the control of syphilis and gonorrhea. These diseases must be managed much as tuberculosis has been, through—

1. *Case-finding*

Case-finding is important in order that the public may be safeguarded from infection; that the early case may have the maximum of hope for cure; that the late case may be protected against further progress of disease and a diminution of efficiency; that the sources of infection may be eliminated; and that contacts of known cases may receive the benefit of examination and treatment.

2. *Adequate treatment facilities*

Treatment facilities are essential so that the efforts expended in case-finding may not be wasted; that patients may not have a false sense of security when under care; that the arrest or cure of disease may be extended to the greatest number possible; that infectious cases may be rendered harmless, and the bulk of the problem reduced to the minimum.

3. *Control of the known case through education and follow-up*

Control of cases is necessary so that the work begun in case-finding and treatment may not be wasted; that the community may not harbor dissatisfied, misinformed and discouraged patients who will deter others from treatment; that every person brought under care may be taught pertinent facts about his disease and his responsibility to family and associates; and that these may act as the "leaven" of knowledge in the "lump" of ignorance.

4. *Preventive medical measures*

Such measures are imperative in order that children may be spared such infections as gonococcal ophthalmia neonatorum and congenital syphilis; and that adults may have the benefits of broad prophylactic measures when exposed to these diseases.

5. *Persistent and universal education*

Education is needed so that youth may be safeguarded; that every individual may know the public health significance of syphilis and gonorrhea, the importance of immediate and continued treatment if infected, where to go for treatment, and what to expect from treatment; that the public may be aware of the dangers of drug-store treatment, self-treatment, and the quack doctor; and that they may demand the constant use of measures which will prevent these diseases from attacking the unborn and the newborn child.

OPPORTUNITIES FOR THE NURSE

Such a program is crowded with opportunities for the public health nurse. The keystone of her activities is prevention; case-finding is an integral part of the daily round, and a fundamental contribution to community health work; and teaching is a necessary concomitant of all direct nursing services.

As a health worker with free access to a large proportion of the families in any given community, the nurse must encounter all types of infections, including syphilis and gonorrhea, and her approach to the latter need not be very

different from her technique in other communicable diseases.

The nurse in a generalized public health nursing organization teaches by her very activity in the field of gonorrhea and syphilis control that these diseases are family problems and a necessary part of the family health work. Thus the patient, without knowing that he is learning, begins to take a more wholesome attitude toward a situation which might have been viewed as something shameful, to be hidden and denied —instead of a health problem, to be faced squarely and acted upon constructively.

For instance, assistance is sadly needed for preadolescent girls with gonococcal vulvovaginitis. Medical records show that many of these girls have infections which remain uncured for months and sometimes years, because home treatment is neglected or unskillfully administered. As a matter of fact, every such case, which is not hospitalized, needs home supervision, repeated demonstrations of treatment, and the sane, unemotional viewpoint of a nurse who can assist the patient and the family to become adjusted to a situation which seems to them disastrous.

CASE-FINDING

Because of the nurse's confidential relationship to such families, and because of the fact that she is giving a tangible service by teaching, demonstration, and actually assisting the mother with treatments, she is in a strategic position to learn of the source of infection. Also, through her skill in presenting facts about the infectiousness of gonorrhea, other members of the family may be brought to medical attention as contacts.

Although case-finding in the family is usually prompted by the presence of a known case of gonorrhea or syphilis, there are dramatic instances in which the nurse discovers obscure or isolated cases which show significant symptoms, and through her knowledge of resources for diagnosis and treatment is successful in bringing such patients under medical control.

Again, through the medium of already established maternity programs, public health nurses may extend and strengthen community projects for the prevention of congenital syphilis. If every pregnant woman could be taught that early medical care is essential to her own and her baby's welfare; and if obstetrical examinations included repeated blood tests to discover those mothers, who need antisyphilitic treatment; and if for such mothers, treatment were immediately instituted and continued consistently throughout pregnancy, congenital syphilis would promptly disappear.

Among the special contributions which nurses should be equipped to make are: an alertness to factors in obstetrical histories which may be significant; skill in getting patients under medical care with as little delay as possible; ability to interpret findings to physician or clinic without overstepping the boundaries of professional ethics and prerogatives; successful case-holding through instruction and encouragement of the patient; expertness in the use of community resources to further treatment or to remove obstacles to treatment; and perseverance in bringing familial contacts to medical attention. These are only a few examples of the nurse's privileges and opportunities. Many others, relating to the health department, the clinic, the school and the factory, might also be cited if there were time and space.

PREPARATION OF WORKER

Great impetus would be given to the campaign against syphilis and gonorrhea if public health nurses were actively engaged in the control program, but those who understand this problem are emphatic in their insistence upon adequate preparation of the worker.

Nothing can take the place of up-to-date, exact, scientific and practical knowledge of all significant biological and medical facts, epidemiological considerations, and approved methods of prevention, treatment and cure of syphilis and gonorrhea. This is a necessary foundation. But the superstructure

must be built of knowledge of the local situation, understanding of the functions of agencies, and professional relationships; clear thinking regarding the place of the health officer, the physician, the social worker, the social hygienist, and the peculiar contribution of the public health nurse; ability to coöperate with all kinds of people; and insight into all the complications and implications of syphilis and gonorrhea in personal, family and community life.

However, all this scientific knowledge and skill will be worthless without those equally desirable attributes which might be summed up in the words *balance, perspective, tolerance*—"the capacity to hear the worst or the best in human nature, and to accept it neither as worst nor best, but as life."[6]

"Success," said Maimonides, great Jewish physician and philosopher of the twelfth century, "is the synthesis of four elements: good material with which to work, a good plan according to which it may be fashioned, good technique in the execution of the plan, and finally, a good objective."

SUGGESTIONS FOR STAFF DISCUSSION

1. Under what state and local ordinances are gonorrhea and syphilis reported in your community?

2. How many cases of syphilis and gonorrhea were reported in your community during each of the last ten years? Do you believe that these figures represent the actual incidence of gonorrhea and syphilis in your community? If not, why not?

3. What local agencies are taking part in controlling these diseases? What is your relationship to these groups?

4. What is your particular contribution, as an individual or organization, to this phase of health work? How might your work be made more effective?

5. Discuss one of your family case histories in which syphilis or gonorrhea is a problem. Discuss case-finding and case-holding methods used. What contribution did other agencies make toward a solution of this case? How essential was the contribution of the nurse in this instance? Wherein did this case fail of adequate solution because of inadequacies in agency coöperation?

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Public Health Nursing in Programs for Crippled Children

By NAOMI DEUTSCH, R.N.

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THE PRESENT social and legislative programs for the care of the hundreds of thousands of crippled children in the United States have been influenced by the interests and activities of many agencies and individuals throughout the country over a period of years. Interest in the care of crippled children was stimulated by the three successive White House Conferences on Child Health and Protection. The studies made for these conferences and the interpretations of the findings have had broad and far-reaching results.

Efforts to carry out the recommendations of the White House Conferences and those of other professional and nonprofessional groups concerned with the care of crippled children have influenced the growth of organized public health nursing services in this field.

It is the rôle of the public health nurse to assist in the interpretation of scientific knowledge to the families of crippled children; in the discovery of potential causes of crippling; in the prevention of serious handicaps through early discovery of remediable conditions; and in rendering skilled care. In addition to assisting families in the fullest use of the clinical resources which the particular community happens to afford, the public health nurse feels responsible for bringing to the attention of the community any lack or inadequacy in such resources.

Since the services of many different types of professional workers are needed for adequate care of the crippled child, close and purposeful relationships among the workers are essential for a sound and productive program.

The effects on family health of poor economic and social circumstances, the realization of which led up to federal legislation for social security, are only too familiar to public health nurses through their continuous and intimate association with the lives of many families. Ability on the part of families to assume full responsibility for the health and welfare of their members decreased under economic stress, and society was faced with the need of assuming greater responsibility for a much larger proportion of families.

The Federal Social Security Act,[1] approved in August 1935, besides including general provisions for the security of the family—such as unemployment compensation, general public health services, and old-age assistance—also provided for some special services to children. Among these are services to crippled children, as specified in Title V, Part 2, of the Act. This portion of the Act, which authorizes an annual appropriation of $2,850,000, has as its purpose to enable "each state to extend and improve (especially in rural areas and in areas suffering from severe economic distress), as far as is practicable under the conditions in such state, services for locating crippled children and for providing medical, surgical, corrective, and other services and care, and facilities for diagnosis, hospitalization, and after-care for children who are crippled or who are suffering from conditions which lead to crippling." This part of the Act is under the administration of the Crippled Children's Division of the Children's Bureau of the U. S. Department of Labor. This division is directed by a physician, and advice is available to the states from medical, social service, and public health nursing consultants of the Bureau.

The state administration devolves upon a state agency equipped to provide

medical care. The Act specifies that plans submitted by the states to the Children's Bureau for approval must meet certain conditions: "(1) financial participation by the state; (2) administration or supervision of administration of the plan by a state agency: (3) such methods of administration (other than those relating to selection, tenure of office, and compensation of personnel) as are necessary for the efficient operation of the plan; (4) such reports by the state agency as the Secretary of Labor may from time to time require; (5) provision for carrying out the purposes of the Act; (6) provision for coöperation with medical, health, nursing and welfare groups and organizations and with any agency in such state charged with administering state laws providing for vocational rehabilitation of physically handicapped children."

At the present time several different types of state agencies are administering services for crippled children under the Act such as: departments of health, departments of public welfare (or child welfare), departments of education, commissions for crippled children, and —in one state—a university hospital.

DEVELOPMENTS PRIOR TO SOCIAL SECURITY ACT

Before describing more fully the present situation in regard to state programs for crippled children which have resulted in this field from the Social Security Act, it might be interesting to review briefly some of the developments in the states before the Act became effective.

Public provisions for the care of crippled children prior to 1935 were sporadic and uneven and in many states totally inadequate if not altogether lacking. From analysis of these provisions we get the following picture of the distribution of services for crippled children by public state agencies authorized to provide care and medical treatment.

In 19 states the services were provided by agencies authorized by law to do so, as follows:

In eight states the agency was the department of health (California, Connecticut, Maryland, Kentucky, Pennsylvania, South Carolina, South Dakota, and Vermont). In two of these states appropriations were small and services were limited. Two states had a state-aided hospital that provided service for crippled children and one had a special state hospital for crippled children, besides a state-aided hospital. In one state the state relief agency was authorized to coöperate with the Federal Government.

In five states the agency was the department of public welfare (North Dakota, New Hampshire, Massachusetts, Ohio, and West Virginia). In two of these the appropriations and services were limited. One had a special state hospital for crippled children, and in one the state relief agency was authorized to coöperate with the Federal Government.

In five states the agency was the department of education (Alabama, Mississippi, Texas, Wisconsin, and Wyoming). In three of these there were limitations of money and service. In two there were state hospitals under the state university.

In one state (New York) there was joint responsibility between the department of health and the department of education. This state had a special state hospital for crippled children.

In 11 states (Washington, Oregon, Utah, Nebraska, Minnesota, Iowa, Missouri, Indiana, Maine, North Carolina, and Virginia), where no state agency was designated by law to provide services for crippled children, provisions were made to some extent, as follows:

In three states relief agencies were authorized to coöperate with the Federal Government. In one of these states there was also a state hospital under a university.

In four states there were special state hospitals for crippled children. In two of these the state health department coöperated in clinics as well; in the other two there were also state university hospitals providing services for crippled children.

In one state there was a state-aided hospital for crippled children.

In three states there were state hospitals for crippled children under university hospitals only.

Before the Social Security Act went into effect no state appropriations (hence no state official agency) existed in nine states (Arizona, Idaho, Nevada, New Mexico, Colorado, Louisiana, Georgia, Delaware, and Rhode Island).

In addition to the state-wide activities of governmental agencies in this field some municipalities also provided

care from official sources, usually through local boards of education.

Since 1922 there has existed in the United States an International Society for Crippled Children, founded in Elyria, Ohio, where it still has its headquarters.[2] This society designates itself a voluntary organization composed of men and women actively interested in the cause of the crippled child. It is primarily a lay organization with many professional members, including orthopedic surgeons and nurses, physical therapists, educators, and social workers. It seeks to coördinate the services of all, and at the same time to enlist the interest and coöperation of lay individuals and organizations and governmental agencies. Forty state societies are affiliated with the national body. The seven earliest to organize were in the following states: Ohio (1919); Michigan and New York (1922); Kentucky, Pennsylvania, Tennessee, and West Virginia (1923). Most of the societies, as they are most commonly called, were organized between 1924 and 1929 and six have been established since 1932.

These societies, which include members of fraternal and civic organizations such as the Elks, the Shriners, the Rotarians, and also interested individuals, have sponsored and supported programs for the care of crippled children. As a consequence of this interest a number of states enacted legislative provision for the care of crippled children.

Since 1920 fifteen Shriners' hospitals for crippled children located in about a dozen states, Hawaii, and Canada have been established. The object of these hospitals is to furnish free hospital service and surgical attention to crippled children. The development of these hospitals has stimulated large numbers of lay people to participate actively in crippled children's programs.

Some city-wide private organizations also have existed for a long time, preeminently the Association for the Aid of Crippled Children in New York City, which was created early in the twentieth century.

Of particular interest to public health nurses (although they have participated to varying extents in the programs of all types of agency) are the special intensive orthopedic nursing services developed by certain pioneering public health nursing associations. These include visiting nurse associations such as those in Boston, Chicago, Milwaukee, Minneapolis, Kansas City, and Brooklyn.

The statement that these few associations made special provisions for orthopedic nursing must not obscure the fact that services for crippled children have always been included in the services of public health nursing agencies that offered health supervision or bedside care, whether visiting nurse associations, county or city health departments, school, industrial, or tuberculosis nursing services. However, no provision was made by most of them for special treatment such as physical therapy. The services of public health nursing agencies in general included arrangements for a follow-up of hospital or clinic care or referral to community resources for such care and the home nursing care of bed or ambulatory patients according to specific medical directions.

To obtain a clearer, fuller understanding of the Social Security Act as a tremendously significant step in the care of crippled children, it seems worth while to trace the historical development of systematic organized effort for such care in the country as a whole.

HISTORY OF ORGANIZED EFFORT

Since 1910, poliomyelitis cases in Vermont have been reported to the State Department of Public Health. In the summer of 1914 a rather severe epidemic occurred, in which about 300 cases of paralysis were reported. It was at this time that the State Department of Public Health made the pioneer attempt to give treatment and after-care to those in danger of becoming crippled from poliomyelitis. Private funds were given to the Health Department for the study of prevention of poliomyelitis, and Dr. Robert W. Lovett of Boston, noted orthopedic surgeon, was asked to come to Vermont to initiate the program of after-care in December 1914. Wilhelmine Wright, his assistant in private practice, worked with him when the first

clinics were held in December 1914 and January 1915.[3]

These first clinics were followed the next summer by another series of clinics. At first no home follow-up nursing care was attempted, because, as Dr. Lovett said later in referring to the situation, "No one sufficiently skilled in muscle training was available." Private physicians, parents, and children were instructed at the clinics. Many of the children came from the rural sections, and travel, particularly in the winter months, was not easy. At the follow-up clinics that Dr. Lovett held in the summer of 1915 the results were so good that he could not help thinking that they might have been better if a trained field worker in physical therapy had been available for home follow-up. In the summer of 1915 a worker equipped for muscle training remained in the state, visiting children and parents to instruct them with regard to the care recommended as a result of clinic examination. It is interesting, in the light of the Social Security Act and its particular emphasis upon care for rural children, that the pioneer effort was essentially a rural project.

Reports during the poliomyelitis epidemic of 1916, in which 27,000 cases were reported (about half of them in New York State), indicated a prevalence of the disease greater than ever before. This created the impetus through which programs to prevent crippling from poliomyelitis were initiated in other states.

In the autumn of 1916 the New York State Department of Health assumed the responsibility for the treatment of poliomyelitis victims in areas outside of New York City. Following the same plan as that used in Vermont, Dr. Lovett initiated and supervised this program. Clinics were held with the assistance of several other orthopedic surgeons. A few nurses who by this time had been taught muscle training were now available for this work. The State was districted, and one nurse remained in each district, giving after-care to children who had been examined at the clinics. Thus began the state-wide program in New York, which has developed until at the present time there are about twenty public health nurses specially prepared for this field of orthopedic nursing on the regular staff of the State Health Department.

In Massachusetts in 1916 the Harvard Poliomyelitis Commission was requested by the State Department of Public Health to take over the care of children who were afflicted during the epidemic. It was particularly desired that diagnosis and treatment be made possible during the acute stage of the disease. In Massachusetts Dr. Lovett followed out the same general plan as that used in Vermont, with some modifications. In the area within twenty miles of Boston children were cared for in a special clinic at the Children's Hospital. In other sections of the state clinics were held in several centers. Nurses trained in orthopedics now were becoming more and more available, a large group having gone to Boston for training with Dr. Lovett. This course included lectures and practice in muscle grading and work in the orthopedic clinics of the out-patient department.

At about this time Minnesota adopted a plan for after-care of children who had had poliomyelitis, whereby public health nurses were added to the State Department of Health personnel to follow up reported cases.

Antedating these state-wide attempts on the part of state health departments, the Association for the Aid of Crippled Children in New York City as early as 1900 provided nurses for visiting in the homes of children crippled from any cause, including poliomyelitis.[4] In 1916, the year of the epidemic of poliomyelitis, the staff of nurses was increased. Home treatments were arranged for children in outlying districts of the Bronx. By 1934 the staff included nineteen graduate nurses whose chief work was visiting crippled children in their homes. The services of the nurses consisted of interpretation of medical instructions from hospitals, clinics, or individual physicians; arrangements for medical care; transportation; and some social services, by referral. At this time about 3000 children were under observation of the association. Home treatments, as

in previous years, were given by a trained masseuse who worked under the direction of a physician.

Concurrent with the rise of state health department activities in relation to after-care of poliomyelitis, orthopedic services in public health nursing associations and visiting nurse associations also began to develop. Among the earliest efforts of this kind was that of the Instructive Visiting Nurse Association of Boston. In the autumn of 1916, at the request of the Massachusetts General Hospital, this association began to give home care to children who had had poliomyelitis and those under care of the orthopedic clinic. Early in 1917 four or five nurses from the association were trained in muscle grading and in after-care of poliomyelitis according to Dr. Lovett's methods, by his associates. Soon afterward the responsibility for the follow-up care of the Boston children under care of the Harvard Infantile Paralysis Commission was given over to the association.

Another extensive program of special orthopedic nursing was begun in 1916 by the Chicago Visiting Nurse Association after the poliomyelitis epidemic.[5, 6] The first nurse of that association to take part in the orthopedic program went to Boston to learn Dr. Lovett's methods, and in successive years others did the same. For five years the association offered special orthopedic nursing care to poliomyelitis cases only, but after that time, to all types of orthopedic cases. This service in 1935 was given through a specialized staff of nurses—an average of 17—all of whom had had thorough preparation for public health nursing before entering the specialized field.

As early as 1912 orthopedic nursing was a part of the service of the Brooklyn Visiting Nurse Association. This phase of care was greatly extended after the 1916 poliomyelitis epidemic, as a larger staff was needed for teaching after-care procedures to mothers in their homes. Gradually special training was provided for nurses of the staff who showed particular interest in and aptitude for orthopedic care, the Brooklyn Rotary Club later providing a number of scholarships at the Long Island College Hospital Medical School. By 1929 the orthopedic staff of the Brooklyn Visiting Nurse Association consisted of a specialized supervisor, six nurses, two physical therapists, and one masseuse.[7]

Since then services for orthopedic care have been made available by the visiting nurse associations of Detroit,[8] Minneapolis, Kansas City, and Milwaukee.

The Milwaukee Visiting Nurse Association added a nurse physical therapist to the staff in 1927. In 1928 the association gave the services of the staff to assist with the establishment of a treatment department in the Lapham Park School for Crippled Children. The demands increased until at present there are eight nurse physical therapists on the staff.

Five nurse physical therapists are at present on the staff of the Community Health Service of Minneapolis (formerly the Minneapolis Visiting Nurse Association). These nurses, along with two occupational therapists, provide services for the handicapped, not only at the patients' homes, but also at the Curative Workshop of Minneapolis, which is a department of the Community Health Service. The Workshop developed from two separate services, a physical therapy program provided by the Junior League and an occupational therapy program provided by the Visiting Nurse Association. These two services since 1932 have been administered by one board, under the professional direction of the Community Health Service.

NEW DEVELOPMENTS

Now that the Social Security Act has been in effect for about a year, what developments are discernible in state programs? By November 1936, 47 states and territories had submitted plans for crippled children's programs to the Children's Bureau for approval, and for 42 of these the plans had been approved and in operation.

A recent summary of the situation in regard to the official state agency administering crippled children's services under the Social Security Act in each of the 47 states and territories for which

plans have been submitted shows the following:

Alaska, California, Colorado, Connecticut, Georgia, Hawaii, Maine, Massachusetts, New Hampshire, New York, North Carolina, Pennsylvania, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wyoming.

Departments of public welfare (or child welfare)—15
Arizona, District of Columbia, Idaho, Illinois, Indiana, Maryland, Minnesota, Nebraska, New Mexico, North Dakota, Ohio, Oregon, South Dakota, Washington, and West Virginia.

Departments of education—5
Alabama, Iowa, Missippi, Texas, and Wisconsin.

Commissions for crippled children—8
Florida, Kansas, Kentucky, Michigan, Montana, New Jersey, Oklahoma, and Tennessee.

State university hospital—1
Missouri.

To determine the extent to which public health nurses are being engaged to take part in these state programs for crippled children a study was made of the 1937 plans of the 42 states and territories having plans approved by the Children's Bureau. The following information in regard to public health nurses was obtained:

In 32 states the plans submitted by the official state agency administering services for crippled children show that 143 public health nurses are to be on the state staff in the fiscal year 1937. In 8 of these states public health nurses had been employed by the state in carrying on programs for crippled children before the Social Security Act became effective. Before the act became effective the 42 public health nurses were so employed in these 8 states; since then 46 more such appointments have been made, making the total 88. The 24 states in which public health nurses had not been previously engaged for state crippled children's programs, now plan to employ 55 public health nurses in the fiscal year 1937.

Of the 10 states that have not planned to employ public health nurses for carrying on programs for crippled children in the fiscal year 1937, 8 plan to employ either physical therapists or social workers for field service for crippled children; about 25 physical therapists (all new appointments but one) are mentioned in the plans, and about 40 social workers, a number of whom are specially trained in medical social work.

In this connection it is interesting to note that the plans for 15 states include employment of medical social workers in addition to public health nurses.

In 7 states the official state agency administering crippled children's services is directed by a public health nurse; in 7, by a social worker; in 6, by some other type of non-medical executive; and in 21, by a physician, either on full time or part time. In one state the position of director has not been filled.

Although many states have not yet completed their appointments, the tendency to rather extensive use of public health nurses in supervisory positions and for field service is apparent.

This tendency, at so early a stage of development of state programs, shows that it is important for the public health nurse as a professional worker to consider how best to fulfill the obligation in this particular type of public health nursing service, how best to prepare herself to contribute effectively and practically to this special branch of public health nursing in relation to the total family health service.

Note: The next in this series of articles on programs for crippled children will appear in the February issue of PUBLIC HEALTH NURSING.

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Maternity and Mental Hygiene

Some Considerations for the Public Health Nurse

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Part II

WHILE no pregnancy can be considered a routine matter by the nurse, many pregnancies proceed with a minimum of physical and mental difficulty. Finances are adequate or can be adapted to the increased needs. The mother and family welcome the pregnancy but do not depend on it for their entire happiness. The mother is glad of the help of the nurse during the antepartum and postpartum periods.

On the other hand, some pregnancies do mean unusual difficulty. In such instances the mother or family may ask the nurse's help in the situation. Occasionally the fact that her services seem unwanted creates a problem for the nurse. Or, the nurse may see needs of which patient and family are unaware. In this article we are discussing the added understanding mental hygiene can bring to certain situations in pregnancy, especially during the antepartum period—situations which complicate the work of the nurse.

WHERE NURSE'S HELP IS REQUESTED

Most easily met of these difficulties are the reality situations about which a puzzled or anxious mother asks the nurse's help. In such instances the need for help not only is present but is recognized by the patient. Requests for information as to available clinics and hospitals and for an explanation of the doctor's orders are examples of such situations. These are instances in which discussion of the mother's difficulty can lead to action on her part which not only may solve her immediate problem but will be the surest way of relieving her anxiety. This might still be true even if the course of action on which the mother decides is not the one which seems ideal to her. For instance, a mother without funds may find the regular care of an efficient maternity clinic satisfying though she prefers the services of a private physician.

Two ways come to mind of insuring that the nurse meets the mother's questions in a constructive way. In the first place, we still need to emphasize that the information which the nurse gives shall be sound, appropriate and as complete as possible. This emphasis is made here not primarily to safeguard the mother from erroneous information, but rather to safeguard her receptive attitude. If she receives the help she needs, the mother may ask again, and perhaps concerning something even more important. If she does not receive appropriate information, the nurse may not be as welcome on her next visit. This point may seem so self-evident as not to need expression. However, which one of us has not allowed herself to "say a piece" to a patient—one which we had carefully prepared in advance of the visit, unaware that the mother would have preferred to discuss another topic. Each of us has at times answered inadequately. Perhaps we did not feel sufficiently sure of ourselves to say that we did not know the answer to the mother's question but that we would obtain the full information and return to discuss it.

The following is an example of a question which received an inadequate answer unsatisfying to the mother. This incident has to do with a mother and baby who had been receiving postpartum and newborn care. A nursing record states in part, "Mrs. F. brought the baby to medical conference. Weight 13 pounds, 6 ounces. Dr. A. told her the baby was too fat, to decrease p.c. formula. Mother asked how a baby could

be too fat. *Advised her that doctors felt too much weight is as bad as too little,* and that she should follow the doctor's orders." Later, in trying to think through her relationship with the mother, the nurse realized that at the time she had thought the mother's question a silly one, rather than indicative of a need for sound information.

A second means of insuring that the nurse is meeting the mother's request for help wisely, is the willingness of the nurse to leave decisions to the mother once the necessary information has been given—if the mother is mentally and physically capable of making decisions. The mother may not complete her plans or place herself under medical care quite as soon as though the decision were made for her or pressure exerted. When she does move, she will do so of her own volition and will be more of a person in her own estimation for so doing. Having taken this step herself, she may wish to take others.

APPARENT RESISTANCE TO NURSE

In contrast to the mothers who ask the nurse for help during the antepartum period are those who appear not to want the nurse at all. Included in this number are mothers who apparently welcome the nurse but who avoid the subject of the pregnancy, or who seem interested in discussing the pregnancy but rarely carry out any of the suggestions for antepartum care considered during the visit. This is an attitude of resistance to antepartum care. In less crystallized form we could call it lack of readiness.

Resistance to the work of the nurse may not mean that the mother entirely rejects her services, though she may appear to do so. All of us have mixed feelings about many of our thoughts and actions. We are ambivalent about our desires—wanting and yet not wanting. Here the mother's resistance certainly is uppermost. Some mothers frankly tell the nurse she is not needed. Others, unable to voice their feeling directly, show it by failure to answer the doorbell, to be at home when the nurse calls, or by obvious indifference to the visit. If the nurse attempts to think through the possible background for this attitude, some of the causative factors may be recognized and a successful working relationship established with the mother after all. These factors will be as many and various as the number of patients. However, some instances of underlying causes which contribute to this attitude can be given.

For one explanation of such an attitude on the mother's part we can look to the relationship between nurse and mother, previously discussed, and illustrate by the following situation.

Mrs. F. was thirty-two years old, a former school teacher who had been married five years. This was her first pregnancy, a much desired one. Her home was in the district of an experienced, attractive nurse, about the same age as the patient. Since the mother was singularly uninformed, the nurse tried to safeguard and help her by explanation and by teaching her certain procedures to add to her comfort and health. After three visits the mother so obviously did not want the nurse that the case was about to be discharged. At this time a transfer of nurses occurred. Warned by the experiences of the first nurse, the new nurse considered the possibility of a different approach. The record gave the mother's birthplace as a city in another state which happened to be the birthplace of the nurse as well. Using this as common ground the nurse worked toward establishing a give-and-take relationship in which she carefully avoided seeming to teach the mother. The mother accepted antepartum care and later was glad to have help with the baby. If possible, she knew even less about caring for babies than she did about caring for herself during pregnancy. The nurse visited her patiently, unobtrusively getting over to the awkward, insecure mother the essentials of infant care. Finally the time came when she could visit less frequently. The mother thanked the nurse for her help and said, "I'm glad I'm not one of those mothers who have to be taught how to take care of their babies." The nurse felt that her thinking had been accurate, that this was a mother who could be a teacher or an equal but who could not accept the rôle of pupil.

It may be, however, that the mother's apparent refusal to work with the nurse is not because of a difficult relationship between nurse and patient but because of a painful experience with which she identifies the nurse and of which she does not wish to be reminded. Recently such a situation presented itself.

The nurse had been visiting in a family where the father proved to have tuberculosis. For unexplained reasons, this family considered tuberculosis as a shameful disease. They did not inform friends or even relatives that the man had entered a sanatorium. The illness was a financial hardship to the man, whose business suffered unless he was there to direct it. The mother shrank from the visits of the nurse although she allowed her to come into the home. She felt toward the nurse some of the dread she felt for the disease due to which the nurse had entered the family. On the father's return from the sanatorium, the mother became pregnant, a pregnancy she did not welcome. When the nurse's visits turned to the subject of the pregnancy the mother said, "I don't know why it is, but even when you talk about the pregnancy, you remind me that we have tuberculosis."

Here was a serious obstacle to the work of the nurse, but here also was proof of a surprisingly thriving relationship between mother and nurse since the mother felt enough at ease to voice her difficulty.

Not a few mothers reject the antepartum work of the nurse because they frankly reject the whole pregnancy. It is less painful for the mother whose baby is unwanted to think about her condition as little as possible and to escape the making of plans as long as she can. If the nurse accepts without surprise or disapproval the fact that the mother does not want her baby; if she has no need to reassure the mother that she soon will welcome the pregnancy, the patient may feel that she has found someone who really understands the situation, and who is interested in her—not exclusively in the coming baby. She need not "pretend" to the nurse. Because she feels at ease she can see the situation more objectively. She may feel that it will be just as well to have the nurse continue her visits since after all the baby really is on the way.

Sometimes, however, a deep resistance to antepartum care persists, with the mother even endangering herself. We know that the rejection of a pregnancy can be so deep as to include a rejection of life. Consciously or unconsciously, the mother may wish to die to escape from what is, to her, an intolerable situation.

On the other hand, the resistance to antepartum care may not be as sweeping as in the instances that have been given. Sometimes the mother genuinely welcomes the nurse but tells her directly or through her behavior that certain phases of the situation are difficult for her. Such, for instance, might be the mother's voiced unwillingness to return at regular intervals to a physician or clinic, or simply her failure to do so in spite of successive appointments made.

Perhaps this is a mother who is unaccustomed to medical care during her pregnancies, and who needs actual and repeated teaching as to the value of medical care, with a careful explanation of the resources available. Gone are the days, however, when faced with failure on some such point, we resorted to wartime tactics and felt that we must "fight it out along this line if it takes all summer." Instead, we take the failure as a signal that we must stop to consider what lies behind the resistance of this otherwise interested and receptive mother. What is she telling us by her behavior? Something, perhaps, of which she herself is not aware.

The mother may simply be telling us that she had a difficult experience at clinic and is unwilling to risk another. One such mother fainted at the clinic following an antiluetic treatment and is afraid to return. Another mother returned to antepartum clinic, but after waiting for two hours, was told she must be transferred to another clinic since her husband had obtained work. In addition, the clinic physician had recommended to this woman treatments which were not available to her. Following these experiences she broke a number of clinic appointments. Another patient felt that she had to wait so long before seeing the physician that clinic attendance was impossible, and so failed to keep return appointments.

These examples are not intended primarily as criticism of clinic procedure since some such difficulties cannot be avoided. It is the feeling of the patient concerning the circumstances which requires emphasis. Some of the mother's adverse feelings toward clinic attendance may be dissipated by: first recog-

nizing that such a feeling not only exists but perhaps exists with reason; showing the mother that the nurse understands her point; then attempting to work out with her a way of simplifying her attendance at clinic.

On the other hand, the mother's resistance to clinic attendance or other medical care may be a reflection of her own unrecognized feelings rather than reluctance to persist in the face of difficulties or to repeat an experience in some ways unpleasant. Perhaps her resentment at the pregnancy is projected onto the clinic, or her rebellion at having to avail herself of clinic service rather than employing a private physician becomes criticism of clinic service. Or, as not infrequently happens, a mother is reluctant to attend clinic because she feels guilty over attempts to abort or because her baby is illegitimate.

Similarly one could discuss factors underlying resistance to other phases of maternity work as, for example, preparation for delivery. One would meet again a need perhaps for direct teaching, perhaps a reaction conditioned by unpleasant experiences, or a reflection of the mother's own emotional difficulties.

We shall go astray and defeat our purposes if we attempt to meet this behavior from the intellectual approach only, with arguments and statistics rather than with an attempt to see what lies behind the behavior. One foreign-born mother reminded a nurse of this when, after having been presented with some factual material, she looked at the nurse coldly and said, "And what is the very good reason?" When the nurse is driven to defensively proving her point, her cause is lost, at least for the moment.

THINK OF THEM AS SYMPTOMS

We have discussed resistance to antepartum care at some length because the variety of causes underlying it is typical of the number underlying other situations of pregnancy. As one of these causative factors repeatedly observed, we suggested the unwanted pregnancy. So far, however, little has been said about such factors as family relationships and the personality needs of the mother which in turn underlie an unwelcome pregnancy. Other frequently recurring situations also command our attention to the degree that we may think of them as constituting the problem rather than realizing that they are merely the symptoms. For instance, frequently mothers are overeager for their babies, their entire happiness apparently dependent on the successful termination of the pregnancy, the pregnancy marked by anxiety and tension. Frequently, also, a mother or father tells the nurse with distress or bitterness of discord between the parents which seems destined to disrupt the family. These situations are symptomatic of underlying difficulties.

It would be misleading, therefore, to attempt a list of problems specific to pregnancy other than those dependent on physiological changes discussed previously.* To do so would be to isolate a certain period in the life of an individual, limiting cause and effect to the comparatively few brief months of pregnancy.

Instead we realize that the life-stream of the mother flows uninterruptedly throughout its course with the pregnancy only a more or less outstanding landmark. Like most streams, the mother's life-stream joins that of others and in the first and last analysis has to do with boundless depths. Perhaps the mother's reactions during this period will be exaggerated or accidents will occur, but in the main she will react to this experience as she reacts to other experiences.

For this reason, it is of more value to study each individual pregnancy in relation to the whole situation of that mother, rather than to fit our thinking about certain formulated problems of pregnancy. This approach later helps the nurse to understand the mother's methods with her children. If the nurse's relationship with the family continues, she will be helping the same individual meet still other situations. New elements will be added. She may find she

was wrong in her previous thinking about the situation. But what is new will always be related to what has occurred.

In addition to problems during the antepartum period with which the family frankly want help from the nurse, and problems which result in apparent resistance to the services of the nurse, there are, then, difficulties which are more apparent to the nurse than to the patient's family and which underlie these situations which we are regarding as symptoms.

What kind of woman carries through a pregnancy with serenity and happiness? What must she have achieved emotionally? One might suggest as three factors in such achievement, emotional maturity sufficient for motherhood; freedom from anxiety and guilt relative to the sex relationship in marriage; ability to solve emotional conflicts without becoming markedly neurotic.

EMOTIONAL IMMATURITY

It is obvious that one can achieve physical maturity without being equally mature emotionally. One may be well on in pregnancy or have borne several children and still be emotionally a child. Perhaps the woman is still very much her mother's or her father's daughter; perhaps, as substitute, she unconsciously needs to be her husband's daughter and to receive his protection and direction. It would be difficult to welcome a pregnancy if one unconsciously preferred to be a child rather than a mother. This need, unrecognized as it is by the mother, sometimes gives rise to behavior which seems strange to the patient's family.

Familiar situations begin to fall in line as one carries this thought through. We remember the young mother who became unreasonably irritated with her husband during pregnancy and spent most of the time at her own mother's home. We remember the mother who felt during pregnancy that she should be "babied" by her husband and other members of the family. There is the mother who, the record states, "acts like a child herself." We recall the mother whom the nurse described with accuracy as treating her new baby "like a doll," interested in the dainty layette but quickly tiring of the baby's care and frightened at the slightest emergency. Again, there is the mother who relies on her own mother or the nurse for decision and planning, or who refuses to allow planning for the coming baby to break into a formerly carefree existence. Sometimes the emotionally immature mother will grow up into motherhood; sometimes she never does so. Under such circumstances, many times the nurse must consider seriously the degree of responsibility which she or another appropriate person must assume temporarily, or permanently. Even a stable, mature woman may need the nurse as a temporary mother especially during the first few months of her pregnancy if, for instance, she is a stranger in the community or a newcomer in the country, with old relationships broken and new ones not yet strong enough to bear strain.

CONFLICT OVER MARITAL RELATIONS

Anxiety and fear have been spoken of elsewhere in this material as possibly based on repression and guilt relative to marital relations.* This is a second factor underlying the mother's adjustment to pregnancy. In its turn the pregnancy may become identified with this relationship, and so be difficult to accept. Relative to this repression, some familiar situations come to mind. Is there more than "modesty" hindering the mother who is "ashamed" to go to the doctor? Have we an inkling as to the conflict expressed by a mother when she said during her first pregnancy, "It makes me sick at my stomach to think of nursing the baby. I think it's disgusting." The nurse whose professional training has helped her to a matter-of-fact approach to the sexual part of the marriage relationship may by her attitude alone be helpful in such circumstances.

NEUROSIS AS ONE SOLUTION

A third factor mentioned is the ability to solve major conflicts without resort to a dangerous degree of neuroti-

cism. One of the most puzzling situations which physicians and nurses face is the attempt to differentiate illness of physical origin from neurotic symptoms. The latter arise from the unconscious conversion of conflict into symptoms which, to the patient, are more acceptable than the actual difficulty. Persistent vomiting in pregnancy may be such a device.

Often it is exceedingly difficult to differentiate the attempt of the body symbolically to rid itself of the foetus, or the attempt of the mother to gain freedom through therapeutic abortion, from true pernicious vomiting. It has been stated that vomiting persisting in pregnancy is rarely toxic, that some women vomit from very slight stimuli and naturally carry this characteristic over into pregnancy, that many women are "essentially unstable, or nervously and physically inadequate and their reaction to any stress is excessive."** However, the nurse has an opportunity to observe the mother in her own home during a number of visits and may be able to make helpful observations. Other physical symptoms may also assert themselves without apparent organic basis. These require the nurse to think through what she knows of the relationships in the family and the patient's attitude as well as the physical régime. It is easy to be carried away to either extreme, contending that the patient is or is not neurotic, sometimes with an element of accusation or defense. For many of us still see an aura of stigma about neuroticism.

We have been discussing in this article situations which commonly complicate the antepartum work of the nurse. For convenience three groupings were suggested: situations on which the family frankly want help from the nurse; apparent resistance to the services of the nurse; situations which present needs more apparent to the nurse than to the patient and family. These situations were described as significant symptoms rather than as problems in themselves. They expressed the degree of emotional achievement of the patient. It is to this degree of achievement that the nurse relates her antepartum service as well as other health work, not envisioning her service as a cure-all but as an aid to healthful mental and physical development.

*See Part I, PUBLIC HEALTH NURSING, December 1936.

**Mussey, Robt. D., and Randall, M. Lawrence. Writing on Toxemias of Pregnancy. In Obstetrics and Gynecology. Edited by Arthur H. Curtis, M.D. W. B. Saunders, Philadelphia, 1934, Vol. 1.

(To be continued)

Looking Into the Past

The following excerpt from an article by Mrs. Isabel W. Lowman published in *The Visiting Nurse Quarterly* for January 1912 recalls vividly some milestones in the history of public health nursing and the plans which culminated in the founding of the National Organization for Public Health Nursing. Other excerpts from early issues of the magazine will appear in later publications, featuring particularly the adjustments and advancements in the last quarter-century.

The author, Mrs. Lowman, was a member of the Board of Directors of the Cleveland Visiting Nurse Association. In this article she makes a plea for high standards for public health nurses. Much that Mrs. Lowman says is pertinent today; in fact, the final paragraph might well be the introduction to "Minimum Qualifications for Those Appointed to Positions in Public Health Nursing," published in 1936!

On the other hand, some of the changing concepts in public health nursing are interestingly brought out, such as the author's reference to visiting nursing as a service designed for the care of the sick poor—a concept which has changed entirely since the publication of this article.

THE NEED OF A STANDARD FOR VISITING NURSING

The generally accepted idea of a visiting nurse in this country is a hospital graduate with some postgraduate training in district work, who as the agent of a benevolent organization exercises her profession in the homes of the sick poor.* She enters the home to give bedside care to some sick member or members of the household, but her peculiar mission is to secure by every possible means a better health standard for the family which, through accident or illness, has come under her care.

Now a great many things enter into the question of this family's moral and physical condition—lack of income, lack of rest, dirty houses, overcrowding, underfeeding, bad air, . . . and very often in addition to these misfortunes, tuberculosis. Other organizations and associations are perhaps at work in the same home helping the family regain its independence and its economic and physical well-being, and the nurse is expected to coöperate intelligently with all these agencies. Her work is not merely palliative, nor just curative: it ought to be in the largest sense constructive. Health should be the vision which leads her and she ought always to feel that if she comes because the family is ill she stays with the hope that it can become a normally healthy family.

We call a district nurse a "visiting nurse"; we call all the nurses who go into the homes to instruct the mother in her care and feeding of young children "visiting nurses"; we call the nurses who take care of and watch over the family which tuberculosis has invaded "visiting nurses." In order to do visiting nurse work she must exercise her profession affirmatively and constructively and with another object in view than that of temporarily taking care of a disease. If she comes and goes with the coming and going of the disease and leaves causes and effects alike unthought of and unaltered she may, it is true, give good bedside care, but she is not doing real visiting nurse work in the sense we understand it today.

I have tried to set forth what an intelligent public now expects from a visiting nurse, but at the same time we must frankly state that there is no authoritatively recognized standard for visiting nursing in this country and no national council or associaton of *nurses* to protect the homes of the sick poor* by fixing a standard and defending this standard against ignorance or deliberate charlatanry. At this present time the standard of visiting nursing in each

*See editor's introductory note.

locality depends upon the entrance requirements of its own individual association and upon the kind and degree of training possessed by the association's superintendent of nurses. And as the lay board of trustees engage this superintendent the ultimate responsibility of the whole matter of standard at present largely rests with them. This of course is an unsafe situation and it is because it is thought to be open to danger and risk that many prominent nurses in different parts of the country are now trying to fix a standard for this social nursing and to organize a council of nurses which will protect this standard from encroachment. However, although there has been no such standard as yet agreed upon, the visiting nurse associations of this country have until very recently held to the best nursing ethics in the management of their work.

We are forced to the conclusion, however, that this has been somewhat a matter of chance and of a mechanical, almost automatic adherence to the first excellent models which were planned by some of the highest minded nurses of the American profession.

It has never occurred to lay boards of management that there could be any other method of organization than the excellent method adopted by the original associations. The first plants were good and the successive plants were started from "slips" cut from the older growth. The Cleveland Association, for instance, was "mothered" during its beginning by the Chicago Association and its superintendents have been nurses trained in the high ethical standards of Harriet Fulmer. It would be interesting to know how many associations, large and small, the Chicago Association has "slip"-planted in this same manner.

As time has gone on the Cleveland Association has undergone the changes which have adapted it to its environment and a somewhat different growth from the parent plant has been the result of these reactions to its surroundings. It also in its turn has been the mother of other organizations to which it has passed on to some extent its pecu-

Borrowed from the Archives of the Metropolitan Life Insurance Company

In the Early Days of Public Health Nursing

liar variations. As a nursing association, however, there has never been the slightest departure from the high standard of entrance requirement with which it was begun.

It seems apparent that to the integrity and fine nursing ideals of the first associations we owe the high character of visiting nursing as now practiced in this country. The first plants were good and the seed was preserved unmixed for wider sowing. Now, however, we find quite suddenly that matters of method and of ethics can be left to the mercy of general interpretation only so long as no powerful suggestion to construe them unwisely is made from without.

It was quite impossible ten years ago to foresee what a whirlwind of altruism would be unchained by the clubbing together of the layman and physician in an effort to hunt out tuberculosis from its nest and hiding places.

Tuberculosis, the hall-mark of misery! That indeed was the inspiration for a world-wide crusade which has opened up and discovered on the one hand such need for succor, and on the other such treasures of helpfulness and good counsel. Gradually the luminous benignant image of health has shone out of all this darkness and confusion and has stamped itself upon the imagination of a whole people. What wonder that since then the greater part of altruistic effort has been in the image and superscription of Health.

Physical and moral health were seen to be the attainable possession of any people who could work together for the common good. For when reason and conscience alike declare the health of a nation to be not only the might of a nation but the rightful possession of its people, the enthusiasm of the first effort put forth to achieve this end will be commensurate with the vision.

The great nurses in this country have always fought for high nursing standards, and their efforts and sacrifices have placed the American profession of nursing in the high place where it finds itself today. It is for the nursing profession to organize in such a way that the treasures of their tradition shall be preserved intact and in the case of visiting nurses such organization must be quickly effected. There is another side of the question to be attentively considered, and that is that a national movement which commands universal sympathy and universal allegiance from the laity and from the medical and nursing professions ought not to be betrayed into losing the idealism and fine feeling which it has so far brought to this work. The best is none too good with which to serve not only the poor but the growing desire to make things better, which is awakening in the heart of our people. Not less education, but more education, not less training, but more training, is what we must demand from our visiting nurses.

I am glad to say again that a group of prominent nurses from several parts of this country are now at work devising a policy which will protect the ideals and standards of visiting nursing from encroachment, and that following the meeting of the Associated Nursing Alumnæ in May this question will probably be dealt with in a way to secure it from the chances of "under-standardized" decisions. It seems peculiarly fitting that the visiting nurses of this country should ask for a national and recognized standard of training.

The visiting nurses . . . do their work with little or no supervision. They are placed in positions where they have to use judgment and a very high degree of skill and initiative. Their tradition has heretofore in this country been unassailed by compromise and they are in a position to insist upon the right to maintain and to increase their standard of excellence.

It seems to be quite conceivable that one of the most important functions of the best associations in this crisis may be to work toward an increasingly high standard of training for the vast body of women who are destined to perform the prophylactic nursing service of this country. ISABEL W. LOWMAN.

Silver Jubilee Year

The day of Jubilee has come.

With the advent of 1937, our plans for celebrating the twenty-fifth anniversary of the founding of the National Organization for Public Health Nursing by adding to its financial strength and public usefulness must result in action.

These plans have been carefully drawn on a nation-wide scale. In the first place, a National Jubilee Committee of twenty-five is being formed to sponsor the celebration and its attendant campaign for new members and special gifts. This committee, headed by Mr. Henry Bruere, President of the Bowery Savings Bank of New York City, has drawn into its membership such distinguished and influential Americans as Newton D. Baker, Frederick Ecker, James Truslow Adams, Charles Francis Adams, Dr. Robert Millikan, William Allen White, Dr. Thomas Parran. Jr., and Mrs. Russell Colgate.

These men and women will give to the campaign of the N.O.P.H.N. the prestige and substantial sponsorship which all persons interested in public health nursing will desire. A New York Silver Jubilee Committee also has been created, headed by Mrs. A. Victor Barnes, and every state in the Union is to have a lay representative to direct the celebration within its borders. Wherever feasible these Jubilee representatives are being asked to form committees not only in their states, but in the larger cities, to give the strength of a thorough organization to our efforts.

Presidents of S.O.P.H.N.'s, chairmen of public health nursing sections, presidents and directors of member agencies are all being asked to join in the work of stimulating an increase in membership.

Our minimum goal for the Jubilee effort has been established. We believe that it is a very appropriate goal for an organization with the past attainments of the N.O.P.H.N. and its tremendous nation-wide demands for service. We are seeking at least $25,000 in special Jubilee gifts from new contributors. We are looking for at least 2500 new members, either nurse or lay, at $3.00 a member. We hope to get twenty-five new life members at $100 each, and twenty-five new public health nursing agency members. We believe that Jubilee gifts and memberships totalling $75,000 are not too much to hope for.

The objectives of our Jubilee campaign have been set to enable the N.O.P.H.N. to reach an even higher degree of usefulness than has been possible in the past. In addition to maintaining its present services of studies, publications, standard-setting, field advisory service, and interpretation of public health nursing to the public, the organization has other demands for service which it should be enabled to meet more adequately. It needs a full-time consultant on school health and a special advisory service for industrial nurses. It hopes to replace its special consultants on mental hygiene and social hygiene, who were discontinued as a part of depression retrenchments. It has many requests from the field to conduct institutes and round tables—many more than it is able to fulfill at present.

These activities will require a large membership; greater financial strength. It is for this reason that we have embarked on our modest campaign for a fitting celebration of the Silver Jubilee. We are going to succeed. Our degree of success will be dependent on the zeal and labor of our friends and members.

Suggestions for celebrations in states and in local communities are being sent out to Jubilee representatives throughout the country, together with information regarding supplies available from the N.O.P.H.N. Every month, up-to-date information on the plans and progress of the Jubilee celebration will appear in PUBLIC HEALTH NURSING.

The hour has struck for friends of public health nursing to go to work. The arrival of this Silver Jubilee has brought us our opportunity. Let us make the most of it.

Amalgamation of Services in Minneapolis

By LAURA A. DRAPER, R.N.
Director, Community Health Service of Minneapolis, Minneapolis, Minnesota

This is the second in a series of articles on successful projects in the consolidation of nursing services. The first was an article by Mabel G. Munro on the amalgamation of services in St. Joseph, Missouri which was published in the November 1936 issue.

A COMMITTEE was appointed in 1933 by the Council of Social Agencies of Minneapolis to study the Visiting Nurse Association and Infant Welfare Society for the purpose of determining whether substantial advantage would result from their amalgamation. This action came after some years of consideration, such a recommendation having been made in 1924 in a study sponsored by the Council.*

The Study Committee was composed of seven members, two representatives from the board of each agency and three members at large. From April through September they met eleven times. To quote from their report: "A review was made of previous studies of the two organizations; graphs were drawn up of the two agencies; a brief of their work was prepared by the executive secretary of each organization showing their aims and purposes; an analysis was made of a group of each agency's records on the same families in their maternity and prenatal departments; frequent conferences were had with the executive secretaries of both organizations; a plan of possible consolidation of the two agencies was charted and discussed with the executive secretaries of both organizations; the opinion of a number of doctors was secured regarding the possibility of combining the work of the two agencies, also as to what attitude certain principals of the medical profession might have toward such a new organization; information regarding the infant welfare and visiting nurse work in other cities was secured by communication."

*Winslow, C.-E. A., and Hiscock, Ira V. The Health Program of Minneapolis. Unpublished study, 1924.

In December 1933 the committee submitted to the directors of the Council a report which concluded as follows: "It is stated as the judgment of a majority of this committee that an organization which would consolidate the two services under one governing board could be relied upon to develop and maintain the best service to the community." This report was adopted by the Council board and submitted to the two agencies involved. The respective boards accepted the report.

Thus it came about that in September 1934 the two agencies were combined into one organization incorporated as the Community Health Service of Minneapolis. The directors of the two amalgamating agencies resigned, and a director was appointed who had had no affiliation with work in Minneapolis. Otherwise the full membership of the boards and staffs of both organizations was merged in the Community Health Service.

For the sake of comparative studies, it seemed desirable to start work on a generalized basis on the first of January if possible. That meant that we had four months in which to prepare. To those contemplating an amalgamation a summary of the urgent considerations will be of interest:

1. Preparation of staff
2. Reconciling of district boundaries of the two former agencies
3. Redistricting the individual nurse's territory so that each could care for work in homes and clinics
4. Working out a schedule to permit each nurse to attend clinic on the days when the mothers from her district attend. Our clinics are on the appointment system

5. Selection of office space
6. Purchase of equipment
7. Integration of record systems.

PREPARATION OF STAFF

Of these the first is obviously the most important, and is the only one about which much need be said. Because of the foresight of the two former directors, we were fortunate in the state of preparedness of the staffs. Not only had most of the nurses had student field work with both agencies, but all the members of the Visiting Nurse Association staff had had three months' experience with the Infant Welfare Society, and many of the Infant Welfare Society had had experience with the Visiting Nurse Association. To refresh them in the part of the work with which they were less familiar, we immediately began an exchange of nurses between the two departments, arranged in three-week periods, and continued this until the end of the year.

In one district, however, we began generalized work almost immediately, in order to try out procedures in a small way before inaugurating them for the whole organization. We believed that this would assist us to correct errors, discover short-cuts and evolve policies. The plan proved helpful from an administrative point of view.

On the first of January 1935, every district began work on a generalized plan. We had formulated our plan of organization but we were aware that we were only at the beginning of the development of a good family health service.

ESTABLISHING INTEGRATED PROGRAM

The period since that time has been devoted to establishing our integrated program. We have tried especially to: (1) enrich the content of the nurses' contribution, (2) effect such economies of time and effort as an amalgamated service may imply. In pursuance of the first objective we appointed assistant supervisors in each of our substations, and we have added to our staff a nutrition consultant—with the expectation of adding a second one soon. Our present staff comprises consultants in child welfare, maternity, mental health, and nutrition. One nurse devotes her time to supervision of cardiac patients, attending the cardiac clinics at our two public hospitals, following up patients in their homes, and supervising cardiac cases carried by staff nurses. We have four supervisors, four assistant supervisors, and forty staff nurses.*

The question as to whether the amalgamation is resulting in financial saving is frequently asked, and difficult to answer. During the first nine months of 1936 our expenditure was $4,000 less than during the same period in 1934. We are not comparing identical situations, however. Our case load this year has been less than in 1934; we have decreased the staff but have increased salaries. These and other factors have complicated the picture. It seems improbable that an agency can ever know with accuracy what amalgamation means in terms of financial results.

Another question which frequently arose in connection with the proposed amalgamation was whether the health education phases of the work might be adversely affected. To quote again from the report of the Study Committee: "Those who hold for maintaining specialized nursing feel that the emergency work of caring for the sick would tend to crowd out the educational work now done by the Infant Welfare Society." That this has not happened is indicated by our records for 1935. The number of clinics, the clinic attendance, and the visits to clinic children in the home—all increased. This may be due in part to the fact that we did not have an extreme pressure of illness in 1935. It is true, however, that all the members of the staff made a conscious effort to safeguard the educational services.

What has the amalgamation meant to patients and to nurses? Although we are too new for many conclusions, we believe in the plan we are following. Numerous incidents have indicated that

*A Curative Workshop carrying on physiotherapy and occupational therapy is a part of the Community Health Service, but a description of it is omitted since it was not affected by the amalgamation.

the nurse brings a more complete knowledge of families to her planning for them. In 1935 our records showed over sixteen hundred cases in which visiting nurse and infant welfare services were given at the same time in a family by one nurse. The grandmother was perhaps a chronic patient, and in the course of her visits the nurse was able to convince the mother of the importance of medical supervision for the baby. In over six hundred instances our initial contact was through the infant-preschool service, and the nurse went to care in illness for a child whose development and history she already knew through clinic contact.

The nurses find interest in the variety of the program and the stimulation of a job which is always demanding. During the past two years we have had approximately a twenty per cent annual turnover and have been able to fill the vacancies with well prepared public health nurses. Many of these new staff members are nurses who have had field practice with us during their public health nursing course at the University of Minnesota, and want more experience in his sort of program. The nurses who leave us say that they feel better prepared to work alone because of this generalized experience.

Since this account of our experience is probably of particular interest to agencies considering amalgamation, I want to conclude with a few points which it may be helpful to remember. Before any decision as to amalgamation is reached, it is essential that there be plenty of time for weighing pros and cons. The board and the staff can more easily meet contingencies if they have foreseen them. If the question is canvassed thoroughly, there can be no fear that conclusions have been too hasty, and there will be time for those who do not want to go along with the new program to make other plans.

An amalgamation is not an easy process. Such considerable adjustments of methods, personalities, and points of view take time and patience. The staff and the board should remember that stresses and strains are apparently inevitable during the period of transition, and do not necessarily mean that their plan is not succeeding. It is well for everyone to understand in the beginning that results will not be achieved immediately. The staff will hardly become an integrated unit in less than two years. Two years more may pass before the new plan is functioning with maximum efficiency. If this is made clear from the start, some disappointments and loss of faith may be avoided.

We are starting our third year with knowledge of ground gained and assurance of accomplishment ahead. That this is so is due to our board and staff who brought to the amalgamation such good will, fortitude, and determination that the new plan could and would succeed.

WANTED: Two copies of "The Evolution of Public Health Nursing" by Annie Maria Brainard, published by W. B. Saunders Company, Philadelphia, 1922. Anyone having a copy or copies of this book which they would be willing to sell, communicate with the Editor, PUBLIC HEALTH NURSING, 50 West 50th Street, New York, N. Y.

Factors in Reading Deficiency

By WILDA ROSEBROOK
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Reading deficiency has been recognized as one of the acute problems of education at the primary, secondary and college levels for the last few years. Some investigators have found that from ten to twelve or fifteen per cent of public school children are unable to read in keeping with their general intellectual ability. Further than this, reading deficiency may be found among all levels of intellectual ability from the subnormal to the superior child.

The history of the attacks on the problem runs true to form. First one theory has been proposed, exploded, and all too often rejected in its entirety. Then another, and another. The intensive studies that have been carried on during the last few years have given us a wide array of hunches or leads upon which to base our study of every child or adult who can not read in keeping with his intellectual ability.

It is interesting to note how many factors have been found which may be contributing to the problem. These contributing factors are so varied and so extensive that it is quite evident the classroom teacher cannot solve the problem alone but may have to call on outside agencies for aid. In many instances the school nurse is her first source of help, for it is the school nurse who has the knowledge and responsibility for helping to determine physical causes of reading deficiency.

What factors should be checked as possible contributing causes? The suggested order of factors as given below is in no sense an arbitrary one. The procedure should be determined by the needs of the individual case and the community resources available.

1. *Intellectual ability*

In most schools children are expected to learn to read in the first grade. The children do have, generally speaking, a chronological age of six years, but it does not follow that all of them have a mental age of six years. Some have a mental age above six years, and others below six years. It is generally agreed that a child should have a mental age of six years and six months before he can be expected to learn to read.

A retarded child may or may not be a reading deficiency case. A child or an adult has a reading deficiency only if and when he is not reading in keeping with his intellectual ability. So if a child is six, seven, or eight and has a mental age of four, five, or just six he presents a different problem from the child who is six, seven, or more and has a mental age which indicates that he has the ability to learn to read.

Intellectual ability should be determined by a competent psychologist, so that an analysis of the results may be obtained. Helpful as the I. Q. or M. A. may be, neither one tells the whole story. A psychologist may find some help in the analysis of the test as to basal age, range, tests passed and failed, quality of response, and the like. (For an analysis of this sort an individual test such as the Stanford-Binet is desirable.)

A complete study of a child's intellectual ability will also involve an appreciation of his intellectual maturity and his intellectual background. What enriching experiences has he had? What are his work habits? How does he express himself? What do his vocabulary and sentence construction reveal? What are his play habits? In what is he interested?

2. *School history*

Did the child enter the first grade at five years of age? If so, was he expected to learn to read? The implication here is that he failed to learn to read because of intellectual immaturity. Although he may be ten or eleven years of age at the time of the study, his con-

tinued experience of failure in the early years may have led him to believe that he never could learn to read.

Did he attend several different schools when he was in the first and second grades? If so, it is quite possible—and in fact probable—that each teacher used a different technique of teaching reading which may have confused him.

Has his school attendance been regular or irregular?

Did, or does, the first and second-grade teacher expect every child to learn to read by the same method, or does she resort to various and sundry devices and techniques?

Was, or is, beginning reading based on the child's experiences? All too often children are expected to learn to read from books or charts the subject matter of which is entirely foreign to the child. A city child may be expected to read about the country before he has had sufficient experience to know what the words mean; a rural child may be expected to read about firemen, without having any definite knowledge about firemen. Children will tend to make more rapid progress in reading if they *know* the *meanings* of the words they are reading.

3. *Home conditions*

The home makes a very definite contribution in one way or another to the reading situation. A few of the outstanding factors which are mentioned frequently as making a positive contribution to reading deficiency are:

The family has no cultural background. The parents are not interested in reading. The child who enters school from such an environment may have no "set" for reading. He may feel no immediate need for learning to read. He may be of average intellectual ability or above, but in such a case the teachers will probably gain time for everybody concerned if they first sell him the idea of "learning to read."

Some parents are overzealous, and may have tried to teach the child to read at home before he was sufficiently mature physically, emotionally, and intellectually. In such a case, the child will have been forced into a *failing* situation. He will thus bring to the school situation an unhealthy attitude toward reading which will have to be changed before much progress can be expected.

There are some parents who persist in doing everything for their children. They keep their children dependent on them for one reason or another. Such parents may be inclined to read too much to their children. Why should the child bother himself with learning to read if the parents satisfy his needs in this connection? Children coming from such homes often enter school with no work habits formed. They don't concentrate. They excel in "running away" and "getting out" of situations and conditions they don't like. They don't know how to apply themselves. These cases present individual problems and have to be treated on an individual basis.

In connection with the question of home conditions, it should be emphasized that the school nurse who is sensitive to all the various aspects of the child's home environment and relationships, can be of inestimable value in interpreting the home situation to the school.

4. *Emotional factors*

Several emotional factors which may be inhibiting progress have been referred to above. An adequate discussion of these factors is beyond the scope of this article. Children do worry and have fears. These worries and fears may or may not be related to the school situation; usually they are not.

Very few teachers, nurses, or even psychologists have sufficient background, training, and skill to treat extreme cases of emotional maladjustment. Nevertheless, all people who are working with children should be expected to be tolerant, sensitive and sympathetic toward the child with problems of any kind. Further than this, they should be sufficiently alert to these problems to know when to seek aid and assistance from specialists in their own or related fields. To be specific, the school nurse must appreciate that a child who is unhappy for any one of the number of

reasons may have as much difficulty learning to read as a child with defective vision. Such a child should be referred to a competent psychologist or psychiatrist just as quickly as the child with defective vision should be referred to a competent ophthalmologist.

5. *Physical factors*

It is in the realm of "contributing physical factors"* that the nurse can be expected to be of greatest service in the prevention and treatment of reading deficiency. It is here that the nurse who appreciates the interrelationships of the emotional, educational, intellectual and physical factors which are besetting the child, teacher, and parents can be of inestimable value. Such a nurse may be the only one who has the *vocabulary* to talk with the child, the parent, the teacher, the school administrator on one hand, and the pediatrician, oculist, or otologist—as the case may be—on the other hand. She is a skilled "go-between," a very essential feature of every school system.

Many studies and theories have been reported from time to time and especially in the last ten or fifteen years, as different individuals have tried to explain why we have reading deficiency and what we should do about it.

Eye movements were the subject of study as early as 1885. Judd[1], Buswell[2], and others have made definite contributions to this study, and their studies indicate that a good reader has three, and not more than four, fixations per line. This holds true for children as well as adults. We also know that the eye does not see words when in motion, only when it is fixated. A poor reader has more fixations and regressions than a good reader.

Since that time numerous studies have been made and various concepts introduced to explain reading deficiencies. These include the theory of handedness and eyedness advocated by Dr. Orton[3, 4], and the concept of muscular imbalance and eye fatigue as a cause of reading disabilities, studied by Dr. Walter F. Dearborn[6] and his students[5] in the psycho-educational laboratory at Harvard University. The recent studies of Dr. E. A. Betts[7] add supporting evidence to the theory that a large percentage of children are failing to learn to read because of the physical immaturity of the eye.

The studies to date indicate that almost any one factor or combination of factors may be the cause of reading deficiency. The individual dealing with reading deficiency must consider everything that has influenced or is influencing the child, including the home, the school, the community, and the child's own development physically, socially, emotionally, and intellectually.

Some obvious suggestions to the school nurse are: (1) to develop a sympathetic and understanding attitude toward all factors which may be involved in reading deficiency; (2) to familiarize herself in a general way with the administrative and educational aspects of the reading situation in her own school system; (3) to become a specialist, as it were, in the study of physical factors* and their relation to reading deficiency.

*EDITOR'S NOTE: For a further discussion on this subject see "Some Physical Aspects of Vision in a School Program for Eye Health," by Francia Baird Crocker, on page 56.

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NOTE: These references are suggested only as a point of departure for further reading.

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Study Program

For Board and Committee Members

THE twenty-fifth birthday of the National Organization for Public Health Nursing in 1937 seems a particularly fitting time for all board members to study the activities and accomplishments of this organization, which exists for the purpose of assisting local agencies, board members, and public health nurses to do a more effective job. The following study outline contains suggestions for ways in which the National Organization (known as the N.O.P.H.N.) can assist you in your work. After your education committee has studied this material, it would be interesting to analyze a day's work of your agency and also to analyze a board meeting to see how often material prepared by the N.O.P.H.N. is being used. Write in for the pamphlets referred to in this outline to assist you in planning or conducting your work.

THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

The National Organization for Public Health Nursing was organized at the Fifteenth Annual Convention of the American Nurses' Association in Chicago, on June 7, 1912, in response to the need for a national organization to develop standards, to outline qualifications for public health nurses, to assist local organizations in analyzing their problems and to act as a clearing house for information concerning public health nursing. In the words of an editorial in the *Visiting Nurse Quarterly* for July 1912, "Coöperation through wise organization practically endows the weakest member of an organization with the strength of the strongest without diminishing the strength of the latter. Whatever has been found to be of practical value to visiting nurse units by the oldest and most active association in this country will become an asset in the common treasury of a national organization."

Immediately the *Visiting Nurse Quarterly*—which had been started in 1909 by the Cleveland Visiting Nurse Association as a quarterly report and had developed into a vehicle for the distribution of the best thinking of the day on matters pertaining to public health nursing—was donated to the National Organization for Public Health Nursing. Later it became *The Public Health Nurse* and is now PUBLIC HEALTH NURSING with a total circulation of 6755 (October 1936).

Public health nursing in the United States began in 1877 with a nursing service under the auspices of the Women's Branch of the New York City Mission. By 1912 there were 899 associations employing 2442 nurses. It is estimated that today the number of nurses has increased to 20,000.

Functions

The purpose of the National Organization for Public Health Nursing is to foster and develop public health nursing throughout the country; to develop standards in qualifications of workers and in practices and policies in public health nursing. To this end the organization serves in an advisory capacity to public health nurses, board and committee members and all others interested in public health nursing; assists in securing adequate opportunities for education and preparation for public health nurses; and assists in the placement of qualified workers. The N.O.P.H.N. coöperates with federal, state, and local social and health agencies to promote the better coördination of public health nursing with all social and health programs.

Advisory service is offered through correspondence, field and office visits, field studies, special statistical studies,

institutes, round tables, and other meetings such as the Biennial Convention, and through publications.

Publications

Following are some of the important publications of the N.O.P.H.N.:

PUBLIC HEALTH NURSING—Official publication of the N.O.P.H.N. $3.00 a year.

LISTENING IN—Three issues yearly. Free to members. A bulletin of information regarding activities of the N.O.P.H.N.

SURVEY OF PUBLIC HEALTH NURSING—This report presents the findings of the survey of fifty-seven public health nursing agencies, with recommendations for improving the quality of public health nursing. The Commonwealth Fund, 41 East 57th Street, New York, N. Y. 1934. $2.00.

MANUAL OF PUBLIC HEALTH NURSING—A guide to nursing care, technical procedure, and content of program. Revised 1932. $1.50.

THE BOARD MEMBERS' MANUAL—A guide for laymen in questions of organization, administration, and the education of board and committee members. Out of print. Revised edition will be available in 1937.

PRINCIPLES AND PRACTICES IN PUBLIC HEALTH NURSING INCLUDING COST ANALYSIS—Prepared for the guidance of executives, supervisors, and board members, that they may compute the cost of a nursing visit and maintain a standard of service consistent with the best public health and medical practice. 1932. $1.75.

PUBLIC HEALTH NURSING IN INDUSTRY—A textbook regarding public health nursing in industry. 1933. $1.75.

Note: The last four publications listed above are published by the Macmillan Company, New York, N. Y.

Administration

The organization is administered by a board of twenty-one members, with a president, first and second vice-presidents, secretary, and treasurer. The president, and the first and second vice-presidents are elected for a two-year period by the membership. The secretary, although elected by the membership, is usually the general director of the organization. The treasurer is appointed by the board. The present staff of the organization consists of nine executives and seventeen clerks. This includes a general director and associate, a business manager, a statistician, and the editor of PUBLIC HEALTH NURSING.

Equal representation of laymen and public health nurses on the Board of Directors reflects the partnership of laymen and public health nurses which the N.O.P.H.N. considers an essential in the successful development of public health nursing. (The term "laymen" when used in this connection is understood to mean individuals other than public health nurses.)

The standard-making functions of the organization are accomplished through committees composed of both laymen and nurses. Thus the Records Committee has prepared a set of record forms and developed statistical procedures which enable organizations to study the adequacy of their services in relation to community needs.

The development of relationships with other national health, educational and welfare agencies is an important factor in the promotion of public health nursing, a factor which contributes also to the fostering of standard practices. This activity may be illustrated by the work of the School Nursing Committee which secures representation for school nursing on national health and educational organizations, and coöperates with the committees of these organizations in the development of standards in school nursing.

Another example of standard making is represented in the work of the N.O.P.H.N. Education Committee which outlines the requirements for and publishes an approved list of courses in public health nursing; and which has outlined and published the "Minimum Qualifications for Those Appointed to Positions in Public Health Nursing."*

Support

The National Organization for Public Health Nursing is a membership agency composed of individual and agency members. Individual members include all those interested in public health nursing —nurses, board and committee members, officials in public health and education, physicians and other public-spirited citizens.

Agency membership is open to any agency employing public health nurses. Associate agency membership is open to agencies interested in but not administratively engaged in public health nursing. In addition to income derived from

membership dues the N.O.P.H.N. receives support from contributions, reimbursements for field service, and the sale of publications.

Summary of services

In outlining some of the ways in which the National Organization for Public Health Nursing can serve your organization, several problems are listed together with the material and services offered by the Organization, which bear specifically on these matters. This list is, of course, only suggestive; any agency can add to the problems listed, and by studying *The Publications List*,* the yearly magazine index (published in the December issue of PUBLIC HEALTH NURSING), and *Serving You Nationally*,* can work out the appropriate material or service available.

HOW N.O.P.H.N. CAN HELP YOU

You want to know whether your public health nursing agency is organized and administered on the soundest possible basis to serve your community.

Compare your constitution and by-laws, your practices and policies with those suggested in the *Board Members' Manual* (now under revision). Select reprints listed under the heading of Board and Committee Members in *The Publications List;** also "Functions in Public Health Nursing,"* which outlines in detail the duties of the nurse in each service.

You will probably also wish to study your source of income, the size of your staff and other questions related to expenditures. For comparison with other agencies see the yearly review; the last one appeared in the October 1935 issue of PUBLIC HEALTH NURSING under the title "Our Annual Inventory." A salary study is also published annually (PUBLIC HEALTH NURSING, April 1936) which will help you to determine the usual salary for various positions in different parts of the country.

You wish to know whether there are gaps or overlapping in the public health nursing service in your community.

Use the Outline for Studying Public Health Nursing* to study your community, listing the agencies and the services each performs. From *The Publications List* select the reprints: "How to Appraise Public Health Nursing," and "How Can Public Health Nursing Services Be Combined." After completing your study of your own organization, you may wish to plan a field survey by a member of the N.O.P.H.N. staff. The charge for such service is usually $30 a day,* but corporate agencies are entitled to a credit of 25 per cent of their total dues, which may be applied to any field service; and the N.O.P.H.N. fees are adjustable, so that no agency should be denied service by its inability to pay.**

You have been asked to offer affiliation to nursing students.

First of all, it should be emphasized that the purpose of student affiliation is the education of the student. The Education Committee of the N.O.P.H.N. recommends that no public health nursing agency offer student affiliation unless it is willing to accept an educational responsibility for the student. To this end qualifications both as to ratio of students to staff nurses and supervisors and qualifications of staff and supervisors have been set up, and certain minimum requirements outlined in "Recommendations on Staff Education Including Student Affiliation."* Staff education programs appear in PUBLIC HEALTH NURSING and are available in reprint form. Bibliographies to assist the director in planning a library for both students and staff can also be secured.* The services of the National Health Library are available to members, both agency and individual, and books may be borrowed for the cost of transportation.

You want to know where to turn for qualified workers.

Write Joint Vocational Service describing the position to be filled, stating qualifications expected (see "Minimum Qualifications for Those Appointed to Positions in Public Health Nursing"), and stating also the salary offered. (To

compare your salaries with those offered by other agencies see yearly salary studies, the last of which appeared in PUBLIC HEALTH NURSING, May 1936.

You are considering affiliation with a Community Chest and wish to know the advantages and disadvantages of such a step, and what changes in your present procedures will be necessary especially in relation to publicity and budget planning.

The following references from PUBLIC HEALTH NURSING may help to provide some background:

Report of the Committee on Community Chest Standards, February 1930, p. 98.

Program Planning in Relation to Budgets, October 1934, p. 522.

When You Present Your Budget to the Community Chest, by Josephine S. Brinsmade, May 1936, p. 322.

If you wish further advice the N.O.P.H.N. will be glad to give it either by correspondence or office interview. Such advice is given in coöperation with the Association of Community Chests and Councils, Inc., and is based on material in the files of both national agencies. The Community Chests and Councils recommends that all agencies participating in Community Chests maintain a year-around publicity program to interpret their service to the community. In addition to frequent articles in PUBLIC HEALTH NURSING on publicity, the N.O.P.H.N. has a set of loan folders with samples of publicity and suggestions for the preparation of publicity material.

*Available free of charge from the National Organization for Public Health Nursing, 50 W. 50th Street, New York, N. Y.

**The $30 covers office time and clerical assistance necessary to write up the report as well as actual field time. When a special trip to a distant point is required, travel expense is necessarily added to this amount.

GUIDE POST FOR BOARD MEMBERS

The fourth in the series of study outlines for board members is to be found just above, starting on page 32.

The early days of public health nursing in the United States and some of its early problems are vividly depicted in an article reprinted from a 1912 *Visiting Nurse Quarterly*. Page 23.

An effective exhibit used by one agency to interpret its public health nursing service to the community is pictured and described on page 53.

Some of the possible causes of reading disability in children are analyzed on page 29.

The responsibilities and qualifications of a nurse in industry are discussed in a lively panel discussion which occurred at the 1936 National Safety Congress. Page 36.

Emotional experiences often accompanying pregnancy and presenting special problems which should be recognized by the nurse are discussed in the second article of a series on maternity and mental hygiene. Page 16.

Some questions which an agency may ask itself in order to study its own accomplishments and needs are outlined in a New Year's editorial on page 1.

Industrial Nursing Pays

*A Panel Discussion**

"INDUSTRIAL nursing pays dividends to everyone in the organization from the employer to the last man!" A panel discussion at the industrial nursing session of the 25th National Safety Congress in Atlantic City, New Jersey, was opened with this challenge by Hortense Gruber, chairman of the N.O.P.H.N. Industrial Nursing Section.

Miss Gruber said that the topic, "Industrial Nursing Pays," was chosen in the belief that it would interest not only nurses but also the other members of industrial organizations who are particularly concerned with the health of employees. That the subject is of general interest was evidenced by the fact that nearly one third of the eighty-five or more people who attended were industrial physicians, safety engineers, personnel directors or employers. Doubtless, the names of well known people appearing on the program as contributors to the panel also formed a reason for attendance. Industrial nurses were particularly pleased that Dr. C. H. Watson, President of the National Safety Council, chose to attend this particular session among the many group meetings held during the morning.

Julia Weder, industrial nurse with the Giant Portland Cement Company in Egypt, Pennsylvania, acted as chairman of the panel and introduced the other members of the audience. The members of the panel represented the various groups in industry, particularly concerned with health and safety.

PANEL PARTICIPANTS

Discussion Leader: Julia Weder, R.N., Giant Portland Cement Co., Egpyt, Pennsylvania.

Industrial Physician: Dr. Loyal A. Shoudy, Chief Surgeon, Bethlehem Steel Co., Bethlehem, Pennsylvania.

Industrial Executive: Charles H. Edgar, Otis Elevator Company, Yonkers, New York.

Personnel Director: Cyrus S. Ching, Director of Industrial and Public Relations, U. S. Rubber Products, Inc., New York, N. Y. (Listed on program but unable to be present.)

Insurance Executive: David S. Beyer, Vice President and Chief Engineer, Liberty Mutual Insurance Co., Boston, Massachusetts.

Industrial Employee: Charles Zeitler, Industrial Service Department, Oxweld Acetylene Co., Newark, New Jersey.

Industrial Nurse: Marion Dowling, R.N., Lowe Paper Co., Ridgefield, New Jersey.

Miss Weder stated that the value of nursing in industry depends upon two factors: first, an understanding on the part of management as to what may be expected from the industrial nurse, and second, the employment of well qualified nurses.

She asked each panel member to speak briefly concerning these factors from the point of view of his particular place in industry.

Miss Weder introduced Dr. Loyal Shoudy as the first speaker because "when in trouble, we nurses always call the doctor first."

Dr. Shoudy: Concerning industrial nursing as viewed from the doctor's standpoint, let us touch a few of the high lights. Let us take for granted first that any nurse who wants to do industrial work must be a graduate of a "class A" nursing school and have a desire to do this work. Let us take for granted also her outstanding interest in her fellow men, and her willingness to work among all classes of people and to do a good job. She must join the doctor in the department that I like to call the department of human engineering.

If she is connected with a plant where there is a full time medical man, the

*A digest of the panel discussion at the industrial nursing session held in cooperation with the National Organization for Public Health Nursing at the National Safety Congress, Atlantic City, New Jersey, October 7, 1936. The quotations from the panel are made possible through the generosity of the National Safety Council in providing a stenotypist. The panel was condensed into form for publication by Ruth Houlton, R.N., Associate Director of the National Organization for Public Health Nursing. See also an editorial by Miss Houlton on page 3. The panel is published simultaneously in the Transactions of the National Safety Council.

nurse must be able to carry on in the way he plans the work. If she is in a smaller plant where she is the "kingpin" in the medical department and the doctor comes only occasionally, her responsibility is greater. Remember I said she must have the proper training to begin with. After that, ability to show kindness and consideration for everyone who has been injured, everyone who is sick, ability to handle them properly, to build up good will between herself and the personnel of the plant or shop—well, I just can't tell you what I think that is worth.

Now another thing we want to see in a nurse who is handling a job mainly by herself, is executive ability. One of the hard things to find, not only in nurses but also in doctors and everyone else, is ability to fit oneself in. As the head of a department, she should be able to fit in with the other departments. Sometimes in a small plant she must do two or three jobs, help the superintendent and the supervisors, be part of the employment management, and do part of what in the large plant is the physician's job. She must have executive ability to fit in with these other parts of the plant.

Another thing that nurses still have to do in many plants is to sell their services to those in charge and at the same time not to oversell them. You will ask me, "Where is one to find the nurse with all these qualifications?" I don't know. Too many times the nurse is chosen because she happens to have been the nurse for the family of the employer or she happens to be the nurse who took care of the employer himself when he was in the hospital last fall. She is selected purely because she is a good special duty or a good hospital nurse. However, all good hospital nurses do not make good industrial nurses and all nurses who can serve well in the sick room at home, cannot go into industry and make good industrial nurses. An industrial viewpoint is necessary, and how can it be secured?

You who have been pioneers in the job have been fortunate enough to pick it up and have it drilled into you. Problems have hit you and you took a look and did what seemed necessary.

We talk in this panel of industrial nurses needing courses in public health nursing. There are courses in social work but every good public health nurse is not necessarily a good industrial nurse. I can not assume that because a nurse has made a success of social work she is going to be a good industrial nurse. Sometimes this means she has the habit of prying into things that are none of her business. I will stop here and let somebody else talk. (Laughter).

Chairman Weder: I am sure that is a challenge. Remember that. When we throw this open for discussion, I am sure that you are going to find fault with it! (Laughter). We are now going to hear the industrial executive's viewpoint from Mr. C. H. Edgar.

Mr. Edgar: In my opinion it is needless to state that an industrial nurse should be a registered nurse, thoroughly experienced in the profession, with good personality and selected with the aid of the industrial physician (whether full time or part time). In addition to this, I feel that the same searching analysis and care should be followed in engaging an industrial nurse as would be given to employing any other employee in a highly responsible technical or professional field, whether the individual is to be trained as an ultimate subexecutive or used for the immediate assignment only.

The industry that feels the need for developing industrial nursing is the one which appreciates the waste caused by human inefficiencies and wants this waste reduced to a minimum. The employer, however, cannot be expected to know the complete application of medical and nursing knowledge. The employer *does* know that he is creating another division and thus adding to the combination of departments already established. He knows that its scope and development must be handled on an economical and business basis. Its growth and justification will depend upon the service it can render beyond that of a mere first aid station.

Management will demand that this division be equipped and started properly. It will approve and authorize its policies, but it will not interfere with minute details or attempt to govern its operations. This means that the employer must seek an applicant well equipped with a diversified and extensive nursing experience. In addition to cooperation with the physician in charge, the employer will look to the nurse for the same constructive suggestions, constant progress and improvement as is expected from any other department head.

An industrial nurse should not be employed with the thought that she is merely an assistant to the industrial physician, but instead that she should be a wide-awake, alert subexecutive working in full cooperation with the organization as a whole. Her interests are those of management as they reach into the fields of employment, safety, health and welfare. Her interests and relationships likewise should extend beyond the plant, and reach into social, health and welfare organizations of the community. The importance of an industrial nurse cannot be overemphasized. She has a twofold task, and must represent both the viewpoint of the employer and the interest of the employee.

A successful industrial nurse is not one who confines her work to nursing only. She must stand out as a leader in accident and illness prevention. She should be prepared to aid and advise wherever health and family welfare are involved. The extent of her services may vary in different types and sizes of business or industry. But whatever the conditions are, she has closer personal contact with a greater number of individuals within the organization than any other worker. Her task, therefore, requires not only education but initiative in developing and expanding undertakings for a healthier and safer place to work, and a healthier and happier group of employees.

Chairman Weder: Thank you, Mr. Edgar. We are going on now with our program. Mr. Beyer is the Vice-President and Chief Engineer of the Liberty Mutual Insurance Company of Boston. He will talk to us from the point of view of the insurance company.

Mr. Beyer: This morning I was talking with a nurse who has spent considerable time in selling the idea of industrial nursing by visiting different plants and talking with the executives. She said she knew all the reasons why industrial nurses should be employed and I told her that this reminded me of a story.

There were a couple of men arguing and having a very heated discussion. I finally heard one say to the other, "Well, there is only one side to this question." And then he added as an afterthought, "Anyway, if there is another side, I don't want to hear it." That is about the way I feel about industrial nursing. I always felt that there could be only one side to the question of whether or not it is desirable and pays dividends. I might cite two or three reasons for that belief.

When we established the first schedule rating system about twenty-five years ago, we put in an item of five per cent direct reduction in all compensation insurance premiums where there was adequate nursing service in plant hospitals. That is one way in which industrial nursing has been recognized for many years by engineers as paying a very direct dividend. With the schedule rating service, the benefit is still there for the employer who is broad-minded and intelligent enough to use the nurse in the plant hospital.

From an insurance standpoint industrial nursing certainly pays by cutting down lost time. This is true even with such minor illnesses as colds. There are many minor treatments which if given at a plant hospital will reduce lost time. This will mean continuity, increased production and saving by preventing minor injuries from developing into major ones. One of the first fatalities our company had to deal with was that of a janitor who when taking an ash can out one morning cut or bruised his ankle. He received no attention and died of blood poisoning. Every time we see one of these injuries

neglected we realize what might have been done by proper treatment on the part of a nurse in the beginning.

From the standpoint of the safety engineer I believe the greatest help we can get is through the constructive assistance of a nurse. Accident frequency is a symptom to the engineer just as the temperature of a patient is a symptom to the doctor. The nurse who follows up an accident can often find the causes and give the engineers the significant little details. I could tell you of many interesting cases that have come under my personal observation where nurses have given the safety engineer the greatest assistance in solving problems.

There is one more point I want to make. I have a list here of about a hundred concerns that have had anywhere from two hundred thousand to eight million man-hours without a lost time accident. The record of eight million man-hours without an accident was made by a large New England concern that has a foundry. This would be equivalent to a hundred-man plant going for forty years without a lost time accident.

After I looked over the list and had given some thought to this matter, I noticed that the majority of the larger plants with low accident rates have industrial nurses.

Chairman Weder: Mr. Charles Zeitler will present to us the point of view of the industrial employee.

Mr. Zeitler: The three previous speakers have covered the question quite thoroughly from top to bottom. There are just two or three words to say, and they are that a good industrial nursing job does pay dividends both to the employer and to the employee. It seems to me that the industrial nurse plays a very important part through the motherly advice which she often gives to the employee. It creates a feeling of good fellowship between the employee and the employer. We feel that she is a necessity in industry.

Chairman Weder: Last but not least, we will hear from the industrial nurse herself. Miss Marion Dowling of the Lowe Paper Company, Ridgefield, New Jersey, and the secretary of the Industrial Nurses' Club of New Jersey, will speak for the industrial nurse.

Miss Dowling: Industrial nursing does pay dividends to the nurse, the employer and the employee. The chief concern of industry is production and production proceeds most smoothly and efficiently when the workers are happy and well. Nurses who have the proper training and temperament and are willing to work to bring about these particular conditions in an industry are invaluable. To illustrate, I might tell you this incident: Not long ago one of our men had his only son in the hospital to have his tonsils out. To doctors and nurses that doesn't sound very bad but to a lay person it is very serious. The father was doing a particular piece of work that day and underneath he was bothered about his child in the hospital. I went to the hospital to see the boy and when I came back I could report, "I have seen Junior. He is out of ether, his pulse is good and the nurses say that he is a good boy."

He said, "Whew! What that means to me, you will never know!" He then went on about the job which he had to do and did it in fine style, having been relieved about his youngster.

MEETING OPENED FOR DISCUSSION

After each of the members of the panel had spoken, the meeting was thrown open to the entire group for discussion which centered chiefly about two subjects:

1. Desirable qualifications and preparation for nurses in industry.
2. Standing orders.

Space does not permit inclusion of all this discussion. Preparation of the industrial nurse through a public health nursing course was championed by Miss Dowling. She said, "Whether the people we care for are fifty or fifty thousand, they are still a part of the 'public'. I think that a public health background is very important to the nurse in industry. Public health nurses are prepared to teach and I think that they know when to mind their own busi-

ness. I am sure they know when a matter is the public's business."

Dr. Shoudy replied that a public health nursing course "certainly should not handicap" the industrial nurse. "The more she has to give out, the better. I merely said that to understand relationships and fit your program into the whole industrial set-up without overstepping is difficult." Dr. Shoudy again stated his feeling that ability to get on with all sorts of people is essential for the nurse in industry, more than for any other type of nurse.

In the discussion of qualifications for industrial nurses several nurses called attention to the fact that many so-called nurses in industry are not graduate nurses. These attendants sometimes attempt to do things which no registered nurse would venture to undertake, and hence may be a menace to the health of employees.

STANDING ORDERS

Discussion concerning standing orders brought out the following points, contributed by Dr. Watson, Dr. W. J. McConnell of the Metropolitan Life Insurance Company and others.

1. Standing orders are necessary for the industrial nurse since medical supervision is not always immediately available.
2. Standing orders are useful when the physician is present as they save time in repeating routine instructions.
3. The giving of medicine either by the physician or the nurse is becoming less common in industry. Instead, the employee is referred to his family physician.
4. When standing orders do cover the giving of simple drugs, they must be so worded that the nurse gives the drug on the basis of certain symptoms she observes. She must not be put in the position of making diagnoses.
5. Standing orders usually cover first aid treatment for burns, abrasions and other minor injuries. They include instruction as to the type of solutions to use under various conditions. Often, too, they state certain things which should not be done by the nurse. For example, some standing orders permit the nurse to use a soft cotton wad in attempting to remove foreign bodies from the eye but state that no other instrument should be used.
6. Carefully thought out, conservative and frequently revised standing orders protect the physician, the nurse and the patient.

Dr. Shoudy completed the discussion concerning standing orders by pointing out that all work of the medical department in industry should be conducted in strict accordance with the laws of the state and also in accordance with the highest ethical standards.

Miss Weder next called upon Mr. Graham Cole, Safety Director with the Metropolitan Life Insurance Company.

Mr. Cole: (Quoted in part). This has been a most interesting discussion and I was particularly gratified to note the extreme interest that has been displayed in the entire problem by the people who are on the program. In addition, it is indicative of interest that Dr. Watson, President of the National Safety Council, which is responsible for this conference, is with us and has taken part in the discussion. I am sure that every sectional meeting on the board walk today would be very grateful to have Dr. Watson with them but he is here with us.

I view industrial nursing from the safety engineer's standpoint. I happened to have received my baptism in safety work in the same company that Dr. Shoudy is connected with and I know the value of the nurse from that angle. When we consider qualifications of nurses I immediately think of the qualifications I would like to see in the nurse who would fit in effectively with what I want to accomplish, namely the prevention of accidents.

You, the nurse, attend the injured employees under the doctor's instructions and standing orders, if you will. (I thought that "standing orders" applied to the army, but I have learned something this morning). You receive

the employee, frequently after I, the safety engineer, have failed in preventing him from getting into difficulty. You and the doctor are the people that I am then depending upon to keep that case from becoming serious and raising my severity rate.

I am going to be just as frank as Dr. Shoudy was when he started this discussion. I have met two types of nurses in industrial plants. One type of nurse has a job and is interested only in keeping it. She thinks her job is merely to carry out the orders of the doctor and to give proper treatment. Fortunately all nurses in industry are not of this type.

I find the other type of nurse too. I will not attempt to classify her in technical terms. She is a nurse who believes that she has an important part to play in the industrial organization, and she has not erred. Dr. Shoudy warned you against trying to put your nose into the other fellow's business. However, you do not err when you try to point out unsafe plant conditions which have come to your attention.

Instead, you will have found your niche in that organization and become an influencing factor in that company. I will say that when I have found this type of nurse, I have found an industrial plant more and more sold to the value of the nurse. I have found nurses who have become invaluable to the organization. They have built themselves into their organizations.

Twenty years ago in industrial work, a safety engineer was frequently looked upon as a necessary nuisance. The industrial nurse does not wish to be so classified. It is necessary that she build herself into the organization. Her position is indispensable in industry, but the employer does not yet know that in every case.

Dr. Shoudy: How is the nurse going to help the safety engineer?

Mr. Cole: The industrial safety engineers are interested in the prevention of accidents. To my mind, the industrial nurse is in a splendid position to assist and to advise them.

The nurse receives the employee at the time when he is most susceptible to education for prevention of accidents. Maybe I have been talking to some man for months on safety. Perhaps he has said, "That's fine, Cole, you have a lot of good suggestions, but I have never been hurt." When this fellow has had an accident and comes to the dispensary, however, he listens. The most effective time is right after he has been injured and when he is seeking help. You are the "White Angel," so to speak. Then you are in a position to help him and he is susceptible to education. You can talk to him about the cause of the accident and he will tell you things he won't tell two hours afterwards. You have a splendid opportunity to help the safety engineer by assisting him in finding out the dangerous situations in the plants which come to your attention through accidents.

Dr. Shoudy: In order for a nurse to give you that information, is it not important that she should know her industry?

CORRELATION BETWEEN ACCIDENTS AND HEALTH

Mr. Cole: Absolutely. There is one other phase of the problem that I am interested in as a safety engineer and with which I think the nurse can help. We feel there is a more or less definite correlation between the occurrence of an accident and the physical condition of the human being. Where should we go to get definite information? You people are in close daily touch with the employees in your organization. I would like to see the industrial nurse give some attention to the relationship between accidents and the physical condition of human beings who are injured.

The nurse meets employees coming in for treatment. If she will watch them she can see if there is a continued recurrence of ill health. If the man is coming in every two or three days asking for aspirin tablets, that indicates something may be wrong with his general condition. The nurse should watch those cases. If she finds there is an undue proportion of such individuals who eventually come in to have a finger tied up, we want to know about that relationship.

Now if I am to expect all that from you, what should I do to help you in carrying out these responsibilities? You can't report on conditions in a plant if you have never seen them. You can't tell me about things that I want to know unless you have some idea of what I want to know. You meet employees in the dispensary. Should I, as a plant engineer take you out into the plant? Should I provide an opportunity for you to see at first hand the situations under which the employees are meeting accidents?

To what extent should I, as a safety engineer, assist you, the industrial nurse, in gaining the kind of information you want, and what is that information? Will someone give me an answer?

Miss Dowling: I should like to say that the industrial nurse need not wait to be taken to the site of the accident but might go of her own accord to investigate the matter. Of course, this will depend upon the size of the plant and whether a safety engineer is employed.

H. N. Welch (Bloomfield, New Jersey): I might offer a comment. I have the safety and personnel work in our company and the nurse is one of my very valuable co-workers. I find that it is quite frequently of importance to go with her, after a minor or more serious accident, to the scene of the accident and let her get the exact picture. She will be able then in subsequent accidents to know the conditions under which the employee works. I think that the safety management must cooperate with the nurse and give his knowledge of the plant conditions to her in the same manner that he expects her to keep him posted.

Chairman Weder: May I ask, does your nurse function as a member of the safety committee?

Mr. Welch: Indirectly. In some cases she has been a bona-fide member of the safety committee.

Nevada M. Evans (Philadelphia, Pennsylvania): Miss Weder, should an industrial nurse attend safety meetings?

Chairman Weder: Will you answer that, Mr. Cole?

Mr. Cole: I think that is a difficult question to answer generally, as it depends on operation and the type of activities conducted. There are certain conditions where it would not be best and there are others where it would be highly desirable.

CONTRIBUTION OF NURSE

Chairman Weder: Don't you think the nurse offers a valuable contribution to the safety work just by her attitude when an injured man comes into the first aid room? I have seen nurses who, when a man comes in with a little cut, give little attention to it. But if a nurse is cordial and shows the man that she is concerned over the small things, it seems to me she makes a contribution to the safety work.

Mr. Cole: That is most important in industry. There is one other thing I want to say; namely, that there is need for the nurse to have a proper relationship with the supervisory force. I can't imagine a qualified nurse in an industrial plant hesitating to go around the industrial plant. If she has developed the right kind of relationship with the supervisory force and they are sold on her work, they will provide opportunity and give her time.

(A number of interesting contributions from nurses as to things they are doing in their respective industrial plants are omitted here for lack of space).

Chairman Weder: There are other things in addition to first aid that the nurse does. What about the help the nurse gives in the home problems of employees? Many industrial nurses do go into the homes. Even if there weren't any safety department or medical department there would still be need for the nurses who have had public health training. When called into the family to give bedside nursing or other help, they look into the medical and social problems of the family and help solve them.

I am sorry that our time is so

limited. There are many things that we could discuss here. However, I am going to ask Miss Joanna M. Johnson to make a summary of the discussion now.

Miss Johnson (Employees Mutual Insurance Company, Chicago): It is certainly wonderful to have so many here who are taking an active interest in our group. I don't think that we have used our doctors and safety engineers enough. There is one point that we haven't touched on and one that I think we should mention; namely, the following up of the physical examination. In large plants this is done by the doctor who gives full time to the work. That isn't true in the smaller plants.

Physical examinations, if properly followed up, will fit the man for the job. The doctors in industry don't take care of these cases; they can't. But employees can be referred to the family doctor. There is no use for the man to know about his defects unless he does something about them. We, as nurses, can encourage these men to have their defects followed up.

Some of you may have stenographers to do your records but most of us do not. We are in small plants and we must do these things ourselves. If you make up a card file, defects can be easily kept track of. One of the nurses has tried a clever method at the Beloit Iron Works. She has a little red clip placed on the card for a heart case, perhaps a blue clip for bad teeth, a yellow clip for poor vision, and so forth. At that particular plant about ninety-five per cent of the poor vision cases have been corrected; dental work has been done on practically all cases having need of it. There are several diabetic patients who are under treatment also. To me this is one of the most important contributions that industrial nurses can make and it creates a demand also for the services of doctors in the communities.

I think Dr. Shoudy brought out beautifully the importance of creating good will. If we aren't interested in creating good will, if we aren't anxious to serve, then we aren't true industrial nurses.

Insurance rates were mentioned and since I am representing an insurance company, naturally I am interested in rates. All of us should be. If the insurance companies would continue to make it a practice to give a decrease in insurance rates because of nursing service, I think it would help to get a great many more nurses in industry.

Mr. Beyer: I have always hoped that.

Miss Johnson: I don't think that five per cent is enough. I think it should be ten per cent.

Standing orders are a fine thing. This has been a problem for most of us in industry. I think that we need standing orders. Just how they are to be arranged, must be worked out with the doctor and the nurse in each industry. The Wisconsin State Medical Society has issued a pamphlet containing standing orders. The list is simple. It is brought to the individual plant physician and is left at the plant. This makes us feel that we are working with the medical society and that they appreciate the power for good that we have.

Then as to the duty of the nurse as an educator. This was brought out by the employer, and I think, by the employee. The influence that she has in safety work is vastly important. She sees the man at the time that he is most interested in the injury he has received. At that time she can help the safety man most by encouraging employees to report promptly.

There are a hundred other things that were not brought up that I think nurses are doing. The nurse going through the plant has a definite influence in creating a better place for the men to work. She does that by making comments as to the plant housekeeping, good paint, and other things. The men will try to make the place look better when she comes again. I know one plant this spring that spent one thousand dollars on paint because we brought up the idea of good housekeeping in one of our meetings and

asked the foreman to dispose of rubbish.

Our chief problem at the present time is, I believe, that of educating the employers as to what the industrial nurse can do. I know dozens of plants in which the employers should be convinced of the value of industrial nursing.

Following the panel discussion, the industrial nurses held a luncheon meeting at which Hortense Gruber acted as chairman and W. H. Cameron, Managing Director of the National Safety Council, was the chief speaker. Encouraged by Mr. Cameron, the group asked that a committee be appointed to consider plans for developing a strong industrial nursing section to function as a part of both the National Safety Council and the National Organization for Public Health Nursing.

ADDITIONAL CORRECTIONS FOR "WHAT IS WRONG WITH THIS ANNUAL REPORT?"

In November we published a "What Is Wrong with This Annual Report?" (See page 754 of that issue.) We are now adding several further suggestions as to ways in which this report could have been made more effective.

Report as a Whole

Short concise paragraphs with spaces between each paragraph and slightly wider spaces between main topics add to the clarity of the report and facilitate reading. These simple devices may mean the difference between a report's being read or merely filed away—or even relegated to the waste basket unread.

The use of simple sketches, line drawings, or other types of illustrations adds greatly to the attractiveness of a report.

Treasurer's Report

The question might be asked: Is relief an appropriate charge against a health agency? If so, is it handled by a subcommittee? From the size of this item one would judge that it is incidental relief, which would seem to indicate that there are properly constituted relief agencies to take care of the main relief load. Better relationships and more constructive work are generally found where all relief problems are referred to the proper agencies.

Director's Report

As stated in the previous corrections, this report is entirely a quantitative one, giving no indication of the service rendered in terms of quality. However, the quantity of service could be more adequately reflected even in these bare figures by clearer classifications. For example, are "school nursing visits" visits to homes or schools, or both? Do maternity visits include those to the baby and mother or only to the mother?

CHECK AND DOUBLE CHECK

Our attention has recently been called to discrepancies which frequently appear between figures given in annual reports and those published in news articles about the report. Sometimes this is apparently due to the use of different classifications for visits in the two types of publication; but such differences are confusing.

Inasmuch as annual reports constitute the agency's accounting to the public for the funds which it has expended, it is of the utmost importance that all figures relative to volume of work done be accurate; and further that when the annual report forms the basis for a news item, such figures agree exactly with those in the printed annual report.

Nurse-of-the-Month

RUBY RIPPERTON

Texas

Ruby Sapp helped constitute a family of six children, being the fifth in line for title of oldest child of Dr. and Mrs. J. M. Sapp of Lufkin, Texas.

After an elementary and high school education in Eastern Texas and Louisiana, Ruby graduated from the nursing school of Schumpert Sanitarium, Shreveport, Louisiana. She went immediately into the Navy Nurse Corps, but after nine months resigned to become Mrs. Ripperton. She then did private duty in several states for about five years.

In October 1930, after three months of postgraduate study in public health nursing at the University of Minnesota, she started work as a school nurse in Amarillo, Texas. This position continued for five years, punctuated by two other summers in public health work at the University. She resigned the school position in January 1935 to accept a civil service appointment in the Panama Canal Zone. After seven months at the Gorgas Hospital there, she returned to Texas to enter public health nursing again, and is now working as county nurse in Wilbarger County.

We are in Vernon, Texas, just before the curtain is raised on a meeting of the Wilbarger County Health Committee. This September meeting marks the beginning of the year's activities and the Chairman of the County Public Health Board has asked the chairmen of the various standing committees to outline their duties and plans for the coming year. The county nurse sits close by ready to answer any questions and eager to listen to the reports of these lay persons whose interest and support are so vital to her program.

But before the curtain goes up, let us review a few facts about Wilbarger County. Vernon, where the county nurse has her office in the fine County Court House, is the largest town, boasting a population of 10,000. The County itself covers an area of 928 square miles of essentially rural territory and is known as one of the State's best cotton sections. The total population of the County is approximately thirty thousand.

The curtain rises

CHAIRMAN (A farmer and business man): Most of us know our duties, but to inspire the continued effort of old members and to inform the new members as to our program, it is necessary for us to discuss what we did last year and some of the things we hope to do in the future.

First we shall hear from the Program Chairman.

PROGRAM CHAIRMAN (A woman who never admits it can't be done): As you know, our Wilbarger County Health Committee meets once a month here in the office of our county nurse, at which time we listen to her monthly report and the reports from various standing committees, and then participate in an educational program.

Please look over our 1936-37 Year Book. This is the first time we have had one. Notice the programs and the speakers we have had. Most of the speakers are members of our own Health Committee. These meetings have been most inter-

esting as you can see. September—School Health; October—Community Health; November—Syphilis; and so on throughout the year until June when we had a social gathering and election of officers. More and more people are coming to our meetings, to which the public is always cordially invited. We are glad to notice that parent-teacher association groups often attend.

CHAIRMAN: I'm now going to call on one of the most important offices of the Committee—the Chairman of our Maternal and Infant Program.

MATERNAL AND INFANT PROGRAM CHAIRMAN (A young and eager mother who resigned from two bridge clubs so that she might be a better member of the County Public Health Board): Last year the nurse visited all antepartum patients whose names were referred to her, the first object of her visits being to get the mothers under the care of a physician. She also sent a copy of each baby's certificate of birth to the parents with a mimeographed copy of "The Reason for a Birth Certificate" and a leaflet on infant care. This leaflet was prepared by the nurse and approved by our county medical society. A pamphlet on diphtheria immunization was also enclosed. The State is now sending out copies of birth certificates when requests are made to that office.

My chief business is to find every expectant mother I can through every available source—church, school, friends—and to give their names to the nurse. The amount of work she does depends on the doctor in charge. We also have our plans for getting in touch with expectant fathers. There are maternity classes—but I shall leave those for the Chairman of Adult Education to explain.

CHAIRMAN: Will the Adult Education Chairman please continue?

ADULT EDUCATION CHAIRMAN (A charter member of the Board who has returned as a member after several years' absence): My goodness, I've been learning a lot of new things! We used to think these things were all jobs for the nurse. But it seems we've been growing, and one of our members who attended the Biennial Convention in Los Angeles this summer told me bigger and better lay participation was stressed by all those who were supposed to know.

Last year our nurse taught health classes in several rural communities. In one class she had five expectant mothers. The classes are held once a week, and after the first four lessons on antepartum care, they are carried on in the form of a study club. Most of the work covered is on the prenatal, infant and preschool periods. The women are very enthusiastic about the classes, and other women reading about them in the local paper usually make a request to have similar classes held in their own communities.

CHAIRMAN: What are the future plans of the Preschool Chairman?

PRESCHOOL CHAIRMAN (A rural mother with two perfect "preschools"): Mr. Chairman. In the past the preschool child has been more or less included in the school health examinations. Probably a fourth of them have been immunized against diphtheria. Last spring the four ward schools of Vernon had a Summer Round-Up and about fifty per cent of the first grade entrants for this fall were examined by a physician and dentist. This was the first Summer Round-Up we have had for several years and more rural schools had such round-ups than ever before. Our aim this year is to secure a dental and physical examination for all preschool children and to carry on some form of continuous follow-up work.

CHAIRMAN: Next!

SCHOOL CHAIRMAN (A school superintendent of one of the smaller towns in the county and a new member): It appears to be my turn and I'm a little bewildered as to just what my duties are. However, from what our nurse has already told me, I believe my first duty will be to help her to fit her program into the regular curriculum with as little confusion and as much success as possible. It is her belief—and that of school people—that we should have more classroom education in health and greater emphasis on the education of parents as to the physical needs of their children.

As you know, last year almost every elementary school in the county had its pupils examined by a physician and dentist and the majority of these children were immunized against diphtheria and smallpox. Practically all dental defects were corrected but other defects were not so well cared for. The parents pay for these corrections when possible.

Our nurse here conducted four Junior Health Clubs last year and plans to have as many in other schools this year. She chooses the seventh grades for this work. Study outlines for these clubs are supplied by the State Department of Health and cover such subjects as personal hygiene, first aid, and communicable diseases. The nurse tries to make the subject matter fit the life experience of the children.

The teachers, after a group demonstration by the nurse in the use of the Snellen chart, are doing the Snellen test for vision in all the schools this year. A book of instructions from the National Society for the Prevention of Blindness was given to the teachers with each Snellen chart.

CHAIRMAN: A very interesting report. Your turn, Mr. Educational Chairman.

EDUCATIONAL CHAIRMAN (Superintendent of Vernon Schools): Mr. Chairman. The most interesting thing to me that has happened this year is to have two of our members join the National Organization for Public Health Nursing. Also one of these members was elected president and the other secretary of the lay section of the State Organization for Public Health Nursing.

Our nurse, Mrs. Ripperton, and one of our members made a sanitary survey of open toilets this summer. The local paper coöperated by informing the public as to existing conditions and urging that everyone be immunized against typhoid fever as there were several cases in Vernon. This board member and the nurse left a pamphlet on typhoid fever at each home that was visited. We also asked for a sanitary engineer from the State Health Department and the State Epidemiologist to assist us. As a result of all this activity 1593 people were immunized by the county doctor and many others by their family physicians.

The County Tuberculosis Association is conducting an educational program which begins immediately and lasts all fall. All schools, civic clubs, home demonstration clubs and parent-teacher associations are coöperating. They are studying the literature on tuberculosis from our State Sanatorium and from the National Tuberculosis Association. I mention this because the County Association is our offspring, just formed last December, and it is still being assisted by us until it can walk alone.

CHAIRMAN: Now may we have a word from our Supply Chairman?

SUPPLY CHAIRMAN (A woman who helps with everything): I was worried for fear you wouldn't call on me. Have you seen our growing library? Up-to-date books on obstetrics, child care, the family, sex education, and other subjects are now available. Also, have you noticed the attractive screen in this office which is made of hundreds of colored baby pictures? We made it this summer.

CHAIRMAN: I believe you are last on the list, Mr. May Day Chairman.

MAY DAY CHAIRMAN (A young man who knows his business): For six years we have had a May Day Festival. This has become an institution in Wilbarger County. First a May Queen is crowned, and then at her command her subjects enact a pageant on a general health theme. Maypole dances always end the program. Last spring about six or eight thousand people attended the Festival and three thousand children participated. We are planning something entirely different for this year. It will be on the order of a five-ring circus with a different health activity being carried on in each ring.

CHAIRMAN: Thank you all. I am very sorry our Publicity and Welfare Chairmen could not be present. May I add one comment? I believe we should help our nurse more. This is our county and with thirty thousand people and only one nurse, she surely can't do too much without our full coöperation.

How Would You Answer These?

This column has been started in response to an increasing demand from nurses in the field for guidance and help in better preparing themselves to do effective maternity nursing.

The column is intended as a stimulus and guide for study. The questions published this month are selected because they have been repeatedly asked by nurses carrying on a maternity service. The answers will appear in next month's magazine.

In the meantime, won't you answer these questions to the best of your ability and send them signed or unsigned to the Maternity Center Association, 1 East 57th Street, New York, N. Y. Send along, too, any questions you would like to have answered. The continuation of the column as a permanent forum will depend upon the demand and interest of our readers.

1. The blood is supplied to the uterus by .... arteries.
2. The cervix is composed of elastic tissue with very few muscle fibers. Yes ..... No .....
3. The uterus is about ..... inches long, ... inches wide and ..... inches thick.
4. Define first stage of labor.
5. Define second stage of labor. Give signs.
   a. How long should it last in a primipara? .....
   b. How long should it last in a multipara? .....
6. Define third stage of labor.
7. If you went to patient's home to make an antepartum visit and found her in the second stage of labor, what would you do?
   a. .....
   b. .....
   c. .....
   d. .....
   e. .....
8. The fœtal heart rate is about ..... beats.
9. One inch equals ..... centimeters.
10. What is the usual amount of amniotic fluid?
11. How much weight does the average patient gain during pregnancy? When should the gain take place?
12. What is the normal output of urine in 24 hours?
13. Distinguish between a labor pain and a labor contraction.
14. Define "lightening."
15. Define "quickening."
16. The fœtal heart can be heard during a uterine contraction? Yes ..... No .....
17. If a contraction lasts .... the nurse should notify the doctor.
18. Positive signs of pregnancy are:
    a. .....
    b. .....
    c. .....
    d. .....
    e. .....
    f. .....
19. What is "moulding"?
20. Give three functions of the placenta:
    a. .....
    b. .....
    c. .....
21. Hands should be scrubbed for ..... minutes.
22. Water should be boiled for ..... minutes to be sterile.
23. If the nurse is asked to give an anesthetic to an obstetric patient she should:
    a. .....
    b. .....
    c. .....
    d. .....
24. What would you do for a newborn baby to assist with the establishment of respiration?

25. How is maternal mortality computed?

26. What is puerperal sepsis?

27. Indicate four methods by which neonatal mortality may be reduced.
    a. .....
    b. .....
    c. .....
    d. .....

28. Give five causes of abortion.
    a. .....
    b. .....
    c. .....
    d. .....
    e. .....

29. How may nurses help to reduce puerperal infections?
    a. .....
    b. .....
    c. .....
    d. .....
    e. .....

CORRECTION AND CLARIFICATION

The recommendation regarding the use of the terms "antepartum" and "postpartum," appearing on page 731 of the November issue should have been ascribed as follows: The Children's Bureau is using the terms "antepartum" and "postpartum" on its quarterly statistical reports on maternal and child health services under the Social Security Act, based on the recommendations of the Committee on Records and Reports to State and Territorial Health Officers and the United States Public Health Service.* For the sake of uniformity, the N.O.P.H.N. is adopting this terminology and PUBLIC HEALTH NURSING will use it as consistently as possible.

The term "confinement" is to be used by the N.O.P.H.N. in places where better lay understanding will be secured thereby. It is not intended to replace the term "delivery" on records at the present time nor has a recommendation regarding its use been made by the Children's Bureau.

*Tabulation of Health Department Services. Reprint No. 1768 from the Public Health Reports, Vol. 51, No. 36, September 4, 1936, Government Printing Office, Washington, D. C., 1936.

A PROGRAM FOR STAFF EDUCATION IN MATERNAL WELFARE WILL APPEAR IN THE FEBRUARY ISSUE.

WPA Nursing Projects

DURING the fiscal year 1936 approximately 6000 graduate nurses were employed on WPA projects of one type or another. The greatest number of nurses were employed on projects which provided bedside nursing service on a visit basis to families on relief or to families who were unable to provide nursing care for themselves.

Since the beginning of the fiscal year 1937 (beginning July 1, 1936), 75 projects which provide for the employment of graduate nurses in 16 different states have been approved by the Works Progress Administration. The states have been authorized to spend a total of $1,856,655 on these projects. The type of work authorized, the agencies sponsoring each type of project and the allotments authorized may be seen in Table I.

In addition to the 75 projects which have been approved by the Works Progress Administration, 68 additional projects have been submitted and approval is now pending. Many of these projects may be approved and put into operation within the near future.

The Works Progress Administration has issued certain standard "Working Procedures" for projects upon which nurses are to be employed. State and local WPA administrators are urged to set up projects in accordance with the suggested procedures.

HOW PROJECTS ARE REVIEWED BY THE PUBLIC HEALTH SERVICE

When project applications reach the Washington office of the WPA, all projects pertaining to nursing or public health are temporarily held up until they can be reviewed by a representative of the Public Health Service. If the project has been previously referred to the respective state health departments and a written endorsement of the project has already been sent to the Public Health Service by the State Health Commissioner, the Public Health Service merely reviews the project to see that it is properly described and recommends that it be approved without further delay. If the project application was not submitted to the state health department before it was sent to Washington, or if the description is vague as to the duties to be performed and the type of personnel to be used, an air-mail letter is sent by the Public Health Service to the state health department requesting that the proposed

TABLE I—WPA PROJECTS WHICH PROVIDE FOR THE EMPLOYMENT OF GRADUATE NURSES, WHICH HAVE BEEN APPROVED SINCE JULY 1, 1936, ACCORDING TO TYPE OF PROJECT, SPONSORING AGENT, AND ALLOTMENT AUTHORIZED

Type of Project	Local Health Dept.	State Health Dept.	Welfare Dept.	City or County Government	Board of Education	Government Hospital	Total Projects	Allotment to Projects
Visiting Nurses	25	3	2	8	....	....	38	$381,836
Public Health Clinic	7	2	....	....	....	....	9	718,633
Health Education and School Hygiene	7	....	....	1	1	....	9	69,042
Health Camps	3	....	....	....	....	....	3	21,219
Tuberculosis Surveys	2	....	....	1	....	....	3	190,394
Hospital Nursing	....	....	....	....	....	3	3	35,284
Trachoma Clinics	....	....	5	....	....	....	5	240,190
Assistants to County Health Officer	3	1	....	....	....	....	4	52,367
Cancer Study	....	1	....	....	....	....	1	147,690
Total	47	7	7	10	1	3	75	$1,856,655

This information on nursing projects under the Federal Works Progress Administration was supplied by Pearl McIver, R.N., Senior Public Health Nursing Consultant, U. S. Public Health Service, Washington, D. C. (Editor's Note.)

project be reviewed and recommendations made as to its value.

The Public Health Service has two full-time clerks stationed at the WPA offices whose business it is to copy all project applications pertaining to public health (including sanitation and nursing) and to see that each project application is referred to the proper person for review.

POLICIES OF WPA

The WPA has always accepted the recommendation of the Public Health Service with regard to projects which have been recommended for disapproval. Likewise, the WPA has promptly discontinued projects in operation if proof has been presented to show that the projects are not being operated in accordance with the accepted working procedures. The Washington office has been careful to interpret the word "nurse" to mean graduate registered nurse and has consistently refused to approve projects on which non-professional persons were to be assigned to nursing duties.

Some of the values of WPA nursing programs may be summarized as follows:

1. They have given employment to nurses who had no other means of support.

2. They have provided much needed assistance to health departments and hospitals which were very much understaffed.

3. They have introduced many recent graduates of accredited schools of nursing to the field of public health, and aroused their interest in this phase of nursing to the extent that many of them found a way to attend a college or university and to begin their preparation for public health nursing. A considerable number of the nurses selected for training stipends under the provisions of the Social Security Act were selected because they showed a real aptitude for public health nursing in the WPA nursing program.

EDITOR'S NOTE: This article is being published simultaneously, with additional tables, in *The American Journal of Nursing*, January 1937.

THE AMERICAN JOURNAL OF NURSING FOR JANUARY

Silhouette Poster Contest

Here is your chance, all ye artists, to win fame and fortune. We are offering three prizes—a first of $25, a second of $15 and a third of $10—to the lucky winners of this contest.

You are probably all familiar with the silhouette of the nurse who so often strides across these pages and who has recently been promoted to the exalted position of "poster lady." We think this silhouette poster so effective that we are anxious to have another! Such a poster might represent a nurse, a nurse and her car, or a nurse giving some type of public health nursing service. These are merely suggestions. We leave the rest to your ingenuity.

Three judges will pass upon all entries, and the announcement of the winners will be made in the June magazine. Send in your entry early. The contest closes April 1, 1937.

All drawings must be done with India ink on hard-finished paper. And please sign your drawing in tiny letters—like the artist you are! Also, we are asking that you submit your sketch on a sheet of hard-finished paper 10 inches by 12 5/7 inches, placing the silhouette so there will be ample space for a message, preferably at the bottom of the poster. If these requirements are not perfectly clear, or you have any questions to ask, please write to us.

The posters of runners-up will be used for decoration of the magazine. Entries will only be returned upon request and accompanying postage.

The contest is open to anyone.

J.V.S. APPOINTMENTS

Joint Vocational Service reports the following placements and assisted placements during the month of November 1936:

Florence Stein, Chief Consultant Nurse, Arizona State Board of Health, Phoenix, Ariz.

Ruth Burcham, Field Advisory Nurse, State Department of Health, Hartford, Conn.

Mrs. Bertha T. Fradkin, Field Supervisor, Visiting Nurse Association, New Rochelle, N. Y.

Alice Petersen, Senior Nurse, Community Nursing Service, Rockville, Conn.

Mrs. Katherine G. Hunter and Betsy Boylin, Health Counselors, W. K. Kellogg Foundation, Battle Creek, Mich.

Louise Whiteside, School Nurse, Public Schools, Denison, Texas.

Olive Crary, School Nurse-Housekeeper, Grove School, Madison, Conn.

Lena Meo, Senior Nurse, John Hancock Insurance Company Visiting Nurse Service, Hempstead, Long Island, N. Y.

Mrs. Ruth R. Wekerle, County Nurse, Delaware County (State Department of Health), Albany, N. Y.

Frances M. Hersey, Advisory Nurse, Department of Health, Cheyenne, Wyo.

Martha I. Hauk, Educational Consultant Nurse, State Department of Health, Indianapolis, Ind.

Mrs. Mary B. Slattery, Rural Supervisor, State Department of Health, Albany, N. Y.

Pansy Besom, Assistant Superintendent, Visiting Nurse Association, Scranton, Pa.

Ann Schmich, Supervising Nurse, Lake County (State Department of Health), Indianapolis, Ind.

Harriet Russell, Rural Public Health Nurse, State Board of Health, Helena, Mont.

Ruth Laxton, Community Nurse, American Red Cross Chapter, Christian County, Hopkinsville, Ky.

To Staff Positions:

Effie Bailey, Territorial Department of Health, Honolulu, Hawaii.

Mrs. Genevieve B. Nunn, Visiting Nurse Service, Jersey City, N. J.

Bertha Bakanauskas, Visiting Nurse Association, Bernardsville, N. J.

Verna Person, City Department of Health, Fargo, N. D.

Helen Hall, Association for Improving the Condition of the Poor, New York, N. Y.

Jessica Richards, Visiting Nurse Association, Brooklyn, N. Y.

Gleanings

This department is devoted to new ideas regarding improvised equipment, publicity programs, administrative problems, etc. Send us your contributions!

Courtesy Providence (R. I.) District Nursing Association

AN INTERPRETIVE EXHIBIT

This exhibit formed the basis for the Providence (Rhode Island) District Nursing Association's part in a word-of-mouth publicity campaign conducted by the member agencies under the auspices of the Community Fund.

Replacing the Welfare Exposition for the general public conducted previously, a Women's Welfare League was formed of 200 members, each assuming the responsibility for becoming thoroughly familiar with the services of various welfare agencies. As part of the program of informing this group, who in turn were to become interpreters of the services, the several agencies conducted open-house for one week during which time they presented various interpretive projects.

The background of the center table represents the skyline of the city. (We thought at first that the towers were N.O.P.H.N. Headquarters in Radio City.) The foreground is a plat of the city showing the five nursing districts with their names. (Reminiscent of the city's early history, the names of the districts are characteristic—Faith, Hope, Peace, Mercy, and Goodwill!) The seventeen nurse-figures of course represent the staff. This center table, a WPA student project, was done under the direction of the School of Design. Thus the total expense was only eight dollars for the cost of materials.

The other two tables on the sides need little explanation. They were assembled from the supply cupboard.

Interestingly enough, the photograph of this exhibit was taken by a physician affiliated with another agency, thus providing a permanent record of the exhibit with a minimum of expenditure and at the same time demonstrating a coöperative relationship between the agencies.

NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

REPORT OF FALL BOARD MEETINGS

On October 29 and 30 the Finance Committee of the N.O.P.H.N. and the Executive Committee of the Board of Directors met for the regular fall meetings. The most important problem discussed at both meetings was quite naturally the celebration of our twenty-fifth birthday through a Silver Jubilee which we hope will become a nation-wide recognition of the progress in public health nursing. A report of progress to date was read and accepted and plans for the Jubilee definitely outlined. A preliminary announcement of plans appeared on page 800 of the December issue and further details will be found on page 25 of this number.

The finances of the N.O.P.H.N. were reported as satisfactory for 1936. The Executive and Finance Committees both rejoiced in the record number of members which the Business Manager was able to report—8031, the highest in our history. Through this enlargement in our membership and the continued help through our contributors, we hope to close the year with a small bank balance to carry us into 1937.

The Executive Committee recommended the appointment of four additional members to the Board of Directors, openings made through the enlargement of the Board by vote of the membership at the Biennial Convention.

The Executive Committee authorized the President to appoint three representatives from the public health nursing field to the Joint Committee to Study the Birth Control Movement and Its Implications for the Three National Nursing Organizations. Three members were also reappointed to the Board of Directors of the Joint Vocational Service for a three-year period. They are Grace Anderson, Alma C. Haupt, and Mrs. Lewis Thompson.

Progress reports were read from the Board and Committee Members' Section, the School Nursing Section, the Industrial Nursing Section, and from the Education Committee.

The Executive Committee also appointed Hortense Hilbert and Elnora Thomson as two additional members of the Nominating Committee, of which Laura A. Draper of Minneapolis, Minnesota, is chairman.

As its first choice of a time for the 1938 Biennial Convention in Kansas City the Executive Committee approved the tentative date of April 26 to May 3. As its second choice it named May 3 to 7. It also approved participating in the Convention of the American Public Health Association in 1937 if it is held in New York City.

The President was given power to appoint an advisory committee on exhibits for the proposed World's Fair which will be held in New York City in 1939.

The Committee to Study the Functions of the N.O.P.H.N. met on October 31, and is preparing a progress report to be presented at the meeting of the Board of Directors in January.

ADDITIONS TO BOARD

By vote of the membership at the Biennial Convention in Los Angeles, the N.O.P.H.N. By-laws were revised to allow for a larger and more representative Board of Directors. The Board may now number twenty-five, and at its October meeting the four existing vacancies were filled by Board appointment (also in accordance with our By-laws). We therefore welcome to our Board for the biennial period 1936-1938 these four new members: Harry M. Carey, David D. Hunting, Zoe La Forge, and Elizabeth Halliday Hitz.

Another change in the Board has become necessary through the resignation of Dr. Michael M. Davis, our treasurer.

For seven years Dr. Davis has given unsparingly of his advice and help to the N.O.P.H.N., not only on financial matters, which involved some very critical decisions during the depression, but on other matters of general N.O.P.H.N. policy on which his own wide experience in public health qualified him to speak. He has felt for the past year or so that he should withdraw from the treasurership, but generously agreed to fulfill the duties until his successor was found. That event has now occurred and the Board has reluctantly accepted Dr. Davis' resignation, requesting, however, that he remain on our Finance Committee and always feel that his advice on our plans and problems will be welcome.

Our new treasurer is Mr. W. Lawrence McLane of the Marine Midland Trust Company, New York, N. Y. Mr. McLane has entered upon his new duties with enthusiasm and interest and has already been of great assistance to us in forwarding plans for our Silver Jubilee. As Mr. McLane is called upon to travel considerably as a part of his own job, we hope many of our members and contributors will have the opportunity of meeting him personally very soon.

So the new year opens with a new Board, a new treasurer and a new opportunity for all of us to win a place for public health nursing through the nation-wide celebration of our birthday. This seems an appropriate time and place to wish each of our readers equally happy prospects for 1937.

WITH THE STAFF IN THE FIELD

In addition to schedules already announced, December has brought other engagements for the N.O.P.H.N. staff. Miss Deming attended a conference of executives of large visiting nurse associations in the northeastern area, held in Boston, Mass. The Community Health Association acted as hostess to the group. She also made two visits to Washington, D. C., one to attend a meeting of the American Public Welfare Association and again to participate in a conference on venereal disease control work held under the auspices of the United State Public Health Service. She spoke on "Organization and Utilization of Community Resources in a Venereal Disease Control Program" before a section meeting on the medical follow-up of the venereal disease patient.

Miss Davis has spent the greater part of December in the northwest. To her previously announced schedule she added one stop-over visit on her return trip, spending two days in Denver, Colo. January will find Miss Davis visiting Syracuse, N. Y., to speak to the public health nursing students at Syracuse University on the importance of lay participation in public health work. She will also conduct a board members' institute under the auspices of the Volunteer Service Bureau of the Syracuse Welfare Council.

Miss Jones went to Richmond, Va., during December to confer with the director of the public health nursing course for Negro nurses given at the Medical College of Virginia. She also went to St. Louis, Mo., to confer regarding a prospective course in public health nursing.

Miss McNeil attended the Second National Conference in College Hygiene in Washington, D. C.

NEW MAGAZINE COMMITTEE

We should like to call your attention to the personnel of the Magazine Committee for the biennial period 1936-38 as listed on the reverse side of the table of contents page. We know you will be interested to learn the names of those who are helping to shape the destiny of your magazine.

JANUARY BOARD MEETINGS

A meeting of the N.O.P.H.N. Board of Directors will be held during the week of January 25 at the Hotel Roosevelt, New York, N. Y. Also during that same week, the Joint Board of the three national nursing organizations will hold a meeting. Various important committees will convene prior to or during the week of the board meetings.

For J.V.S. Appointments, see page 52.

HIGH POINTS in SCHOOL HEALTH

A SCHOOL PROGRAM FOR EYE HEALTH

Physical Aspects

Part I

Many school children have vision in one eye only; about twenty per cent have some defect of vision—many of the defects so serious that a small group of children, or approximately one child in 500, should not continue in the regular school without special educational tools; and there are a potential number of children who will within the year acquire some eye difficulty through abnormal developmental change, disease or injury. This briefly is the situation unless conditions are better than those in the average school.

THE TEACHER AND EYE HEALTH

Both the physiologic, or normal changes, and the pathologic, or abnormal changes, concern teachers and nurses. Teachers need to understand the normal changes which occur during the period of growth and development in order to plan school activities and grade requirements; to select materials and equipment; and to outline their schedules with an eye health program in mind when assigning tasks requiring the use of the eyes. They are able through observation of children in the course of their work with them to become aware of departures from normal. In order to remove or ameliorate eye difficulties and environmental conditions interfering with the progress of children, the teacher should maintain the closest coöperative relationships with the school physician, the nurse and the parents. Knowledge of the available resources, both private and public, is essential in order for the teacher to participate fully in an eye health program.

DEPENDENCE OF EDUCATION ON SIGHT

Education depends largely upon the sense of sight in carrying out its objective to prepare children for living, and deficient sight interferes with this aim. The child who, because of some eye difficulty sees things larger or smaller than they are is likely to be misunderstood when he reports *what he actually sees*. The child who is unable to see the blackboard misses many stimuli used by the teacher. Words that appear blurred make reading and comprehension more difficult. Prolonged reading when an eye difficulty is present is not conducive to sustained attention.

If the eyes fail to work in coördination there is likely to be loss of efficiency in seeing. Disease or defect of some part of the eye may impair vision by interfering with the formation of a clear image or by obstructing the message on its way to the brain. The visual area in the brain may be so impaired that it is incapable of functioning.

For teachers and nurses to understand thoroughly the process of seeing, they should have a knowledge of the anatomy and physiology of the eye; some knowledge of physics, since light is essential for seeing; and an appreciation of the part that the mental processes play in interpreting what is seen by means of the eyes and light. A simple working concept of the visual mechan-

ism is this: In order to see, we need the eyes with which to see and the brain to interpret the message brought it by light through the eyes. And if the eyes are to function to the best advantage we need:

1. Both eyes working in coördination and free from disease or defect.
2. Necessary physical surroundings for using the eyes with comfort and efficiency.
3. Unobstructed avenues of approach to the visual centers in the brain and abiiity to interpret the message received by the brain.

DISEASES AFFECTING EYE HEALTH

Physical aspects of vision are not limited to the visual mechanism. Such diseases as nervous disorders, focal infections, tuberculosis, syphilis, acute infectious diseases and disorders of metabolism may affect eye health and efficiency. They may even lead to blindness. This has been brought out in a recent study of the most common causes of blindness among children.[1] They are given in percentages as follows:

Causes	Per Cent
Infectious disease	28.6
Neoplasms (tumors)	2.2
Traumatic and chemical injuries	7.8
Toxic poisoning	0.1
Non-infectious systemic diseases	1.2
Congenital and hereditary	51.1
Unspecified etiology	9.0
	100.0

The authors of the study feel that if it were possible to secure family histories and complete physical examinations including the necessary laboratory tests, more children in the group studied would undoubtedly have been found to be blind as the result of infectious diseases, syphilis, and interference with the foetal development.

The above percentages are useful in pointing out that a school program for eye health should continue to emphasize its general communicable disease service; should redouble its efforts to extend its program for the control of tuberculosis, syphilis and gonorrhea; and should make it possible for children to think safety and play safely. Optimal nutrition must be another objective. The essentials for nutrition of the body are the same for the eye. Often an improvement of diseased conditions of the eye is dependent not alone on one factor of nutrition, but on an improvement of the health of the whole body. When a child is hard of hearing he must substitute his eyes for ears; if he is visually handicapped, his ears for eyes. Extra burdens are then placed on one sense or the other. Examination to establish the cause of either difficulty and removal of the cause, when possible to do so, is necessary if the child is to make the desired school progress.

Does the average public health nurse engaged in school nursing appreciate fully the relation between the eye and general health, and is her knowledge of the visual mechanism sufficient to detect deviations from normal and to plan a remedial program when deviations occur—at all times emphasizing a preventive program? As a nursing student, she has had slight opportunity for learning about eye diseases or developmental changes of the eye. Many schools of nursing offer a maximum of five or six lectures in eye, ear, nose and throat nursing. The experiences of students with eye patients are often confined to a small number of patients admitted to the hospital. Yet many of the serious eye difficulties are treated almost entirely in the clinic. In some schools of nursing there are no eye clinics; or where there are eye clinics, the students are not rotated so that they are given an opportunity to observe patients with eye difficulties. It is safe to state that the majority of nurses finish their nursing education without an understanding of how to make a simple test to measure the acuity of central vision.

EYE HEALTH MEASURES

Administering to the needs of all the school children requires a program broad enough to include remedial and preventive measures by:

1. Adopting approved methods for locating children with eye difficulties.
2. Devising a system for adequate follow-up in order to insure competent medical examinations for diagnosis and adequate treatment.
3. Interpreting the medical findings and

their significance to parents and to teachers so that necessary medical and social adjustments may be made.
4. Helping teachers give children the stimulation and satisfactory experience necessary for making them share the responsibility in a conservation of vision program.

In adopting approved methods for locating children with eye difficulties, the following should be included: observation of the child for objective and subjective signs; tests and measurements.

OBSERVATION AND INSTRUCTION

A report of the Joint Committee on Health Problems in Education[2] lists the following behaviors of children to be noted in discovering visual difficulties:

1. Attempts to brush away blur
2. Blinks continually when reading
3. Cries frequently
4. Has frequent fits of temper
5. Holds the book far away from face when reading
6. Holds the book close to eyes when reading, or keeps face close to the page
7. Holds body tense when looking at distant object
8. Is inattentive during reading lesson
9. Is inattentive during wall-chart, map or blackboard lesson
10. Is inattentive during class discussion of field trip or visit to museum
11. Is irritable over work
12. Reads but brief period without stopping
13. Reads when he should be at play
14. Rubs eyes frequently
15. Screws up face when reading
16. Screws up face when looking at distant objects
17. Shuts one eye when reading or covers one when reading
18. Thrusts head forward in an effort to see distant objects
19. Tilts head to one side when reading.

In addition to these evidences the school nurse should observe the lids, reporting any indication of drooping, swelling or discharge. The conjunctiva or lining of the lids should be noted and the child recommended for medical examination if unusual roughness or inflammation is present. The size and shape of the iris and pupil should be noted, and the condition of the cornea should be observed for any evidence of inflammation or scarring. The school nurse should be able to recognize obvious failure of the two eyes to work together. It is not enough to note these evidences and symptoms, but they should be recorded on a permanent record.

Over a period of years much time and effort will be saved if in addition to the school record, there is an eye record filled out by the physician, outlining the following points: (1) the etiological factor responsible for the eye condition, (2) the part of the eye affected, (3) a general description of the condition of the eye, (4) recommendations as to treatment, (5) possible outcome of treatment, (6) tests for visual efficiency including central vision, peripheral vision, and muscle coördination. In addition, sufficient space should be allowed in the record sheet for subsequent examinations. A continuous record by the nurse is necessary for a thorough understanding of the child's eye condition throughout the school period.

FRANCIA BAIRD CROCKER, R.N.
Associate for Nursing Activities, National Society for the Prevention of Blindness, Inc., New York, N. Y.

(To be continued)

REFERENCES

[1] Berens, Conrad, Kerby, C. E., and McKay, Evelyn, C. "The Causes of Blindness in Children." *Journal of the American Medical Association*, 105:1949-1954, December 14, 1935.
[2] National Society for the Prevention of Blindness. Conserving the Sight of School Children. The Society, 50 West 50th Street, New York, Revised Edition, 1935.

SEE ALSO "FACTORS IN READING DEFICIENCY" BY WILDA ROSEBROOK ON PAGE 29.

EDITED BY
ELEANOR W. MUMFORD

THE THEORY OF SOCIAL WORK

By Frank J. Bruno. D. C. Heath & Company, Boston, 1936. $4.00.

The development of social work in variety of program and diversity of techniques has increased our need to draw on other fields of knowledge for basic understanding of human life and the functioning of society. Its specific techniques social work must slowly forge for itself out of its own experience, but it must have as a basis for them the knowledge formulated by specialists in many fields. It is because of this that the membership standards of our professional associations and admission requirements for training schools for social work alike require a considerable number of courses in the biological and social sciences.

The individual social worker needs to see clearly the specific bearing of this knowledge and these theories on his own practice. They are of value only as they become tools which we can use. It is to this end that we shall find the greatest value in Mr. Bruno's book on "The Theory of Social Work." In it he aims to give to the social work practitioner a realization of the way in which the social and biological sciences should influence our practices and determine our programs.

The book covers a wide range of subject matter. It has three main divisions: Biological Elements; Psychological Aspects of Behavior; Social and Economic Environment. In each group certain chapters, such as those on Heredity, Functional Approach to Behavior, The Family, The Community, are devoted to a summing up of current theories in these fields. When these subjects are controversial the differing points of view are presented, sometimes with the statement of a general conclusion, sometimes as problems not yet resolved. In the field of psychology for example, there is a brief analysis of the respective concepts of Watson, Jung, Adler and Freud.

Other chapters relate more specifically to the ideas basic to the practice of social workers—as in those on housing, child labor, etc. Naturally at the present time readers will turn with special interest to the concluding sections dealing with economic theories as to the causes of unemployment, an up-to-date discussion of the care of the unemployed, the various types of social insurance and the problems involved in their administration.

Obviously in a book which covers so wide a range of subject matter, chapters will differ in their adequacy and in the sense of conviction they arouse. Mr. Bruno has chosen to give few foot-note references to his specific source material. There is, however, an excellent descriptive bibliography for each chapter which indicates the range of material on which his generalizations are based. This should stimulate the reader to follow further those topics which arouse his interest or challenge his convictions.

The book was originally prepared as a textbook, but should be of value to any practitioner in the field of social work whose general education has not included these basic courses or who finds that it is not easy to see the relation between the courses he has had and the living, perplexing problems with which social work is concerned. It has an added value in giving to workers in special fields an important conception of the conclusions and philosophies of social workers in other fields, thus helping us all to attain a sense of the fundamental relatedness of all fields of social practice.

MARGARET F. BYINGTON
New York School of Social Work

TEXTBOOK OF ATTENDANT NURSING

By Katharine Shepard, R.N., and Charles H. Lawrence, M.D., F.A.C.P. The Macmillan Company, New York, 1935. $3.00.

This textbook is divided into four sections. The first section deals with anatomy and physiology, the diseases which affect the human body, including communicable diseases, the care of the patient, and instruction concerning the prevention of disease. The following section treats the subject of food from the aspect of meal planning and costs, diets in various diseases and the feeding of infants. The third part, which covers nursing procedure, is very clearly written from the point of view of the home care of the sick and with due regard to the preventive aspects of such care. The last part takes in such questions as behavior of a nurse, personal hygiene, and private nursing.

After years of experience in teaching attendants and careful thought on the subject, the writers have given us as a textbook a much needed and well planned course of study that makes for uniformity in teaching nursing to this group of students—the attendant nurses.

LILLIE YOUNG, R.N.
Brattleboro, Vt.

THE PSYCHOLOGY OF DEALING WITH PEOPLE

By Wendell White, Ph.D. The Macmillan Company, New York, 1936. $2.50.

This book has a title which immediately attracts attention. Who does not feel the need of understanding human behavior, first our own (let us hope) and then the other fellow's.

The author hopes to help you to become more efficient in the science and skill of influencing others to do the thing you want done. Perhaps the thing you want done might be at least slightly modified by sharing with others your objective and methods of obtaining it rather than by searching for their vulnerable spot to gain your end.

Dr. White believes that to influence other people it is necessary to classify and study the fundamental wants of man. These he (with many other psychologists) classifies as follows: the need for recognition, the need for change or variety, the need for love, and the need for security.

The need for recognition is dealt with exclusively in this volume and the author plans to treat of the other three in books to follow.

Since our fundamental interests have a definite relation one to the other, the first one in the lead or perhaps replacing all others, it would have been helpful to have had them discussed in their relationship as an introduction to this first volume.

The material under discussion is not new but it is well organized. The book is well documented.

GRACE L. ANDERSON,
New York, N. Y.

With the very rapid and uncertain changes that have come about in public welfare, the *Proceedings of the National Conference of Social Work*, which held its Sixty-third Annual Session in Atlantic City, New Jersey, from May 18-23, 1936 (published by The University of Chicago Press, 1936), are especially interesting. There are two articles in this volume which supervisors and administrators of public health nursing will not wish to miss. These are "A Philosophy of Supervision in Social Case Work," by Ferne Lowry and "Emotional Growth of the Worker through Supervision," by Florence Hollis. These two articles are as applicable to supervision in public health nursing as in social case work.

RECENT PUBLICATIONS

LENGTH OF LIFE—A STUDY OF THE LIFE TABLE. Louis I. Dublin, Ph.D., and Alfred J. Lotka, D.Sc. The Ronald Press Company, New York, 1935. $5.00.

SEX EDUCATION. Revised edition. Maurice A. Bigelow. The American Social Hygiene Association, New York, 1936. $1.00.

SYPHILIS AND ITS TREATMENT. William A. Hinton, M.D. The Macmillan Company, New York, 1936. $3.50. The primary value of this book to public health workers lies perhaps in the chapter dealing with occurrence and detection of the disease, with emphasis on thorough physical examinations, and also in the chapters which present the sociological aspects of the disease in relation to its transmission through marriage and in relation to congenital syphilis. The book, as its title implies, deals with the remedial aspect of the problem rather than the preventive.

• Two institutes for the training of tuberculosis workers have been definitely decided upon for 1937 by the National Tuberculosis Association. The first will be held in New York, N. Y., February 8 to 20, and the second in Los Angeles, Calif., probably during the last two weeks of June. Definite arrangements for this institute will be announced later.

The New York institute will open on the morning of February 8 at New York University in Washington Square, New York, N. Y. The institute is planned particularly for workers who are now employed as tuberculosis secretaries or staff members or in some other capacity by tuberculosis associations.

No part-time students are taken for the course and auditors are admitted to individual sessions only by special invitation. Registration for the course means that the student will take the entire two weeks.

The only fee charged is a registration fee of $10 payable at the University on the opening day. Living accommodations in the vicinity of Washington Square can be secured at a rate not to exceed $25 a week.

The subject matter of the course covers the following four major divisions:

1. Scientific background, medical and social.
2. Methods and techniques of tuberculosis work including such topics as education, case-finding, treatment, fund-raising.
3. Programs of tuberculosis work—local, state and national.
4. Relationships, including medical, official and non-official, and those with other community agencies.

The course will be under the direction of Dr. Philip P. Jacobs, Director, Publications and Extention, National Tuberculosis Association. For descriptive circular and application blanks, write to Dr. Jacobs at the National Association, 50 West 50th Street, New York, N. Y.

• The fourteenth annual meeting of the American Orthopsychiatric Association will be held at the Roosevelt Hotel, New York, N. Y., February 18-20, 1937. Further information regarding the meeting may be obtained from Dr. George S. Stevenson, National Committee for Mental Hygiene, 50 West 50th Street, New York, N. Y.

• The New England Health Education Association has announced its program for the coming year. Among the meetings to be held which are of special interest to our readers are:

January 12—General Meeting.
"Teaching Health in High Schools," Fannie B. Shaw, School Health Education Secretary, National Tuberculosis Association.

February 2—School Nurses' Section.
Discussion of "Favorable Conditions for Mental Health" by members of the group.

March 2—School Nurses' Section.
Discussion of "Mental Hygiene Opportunities of the School Nurse" by members of the group.

The New Hampshire Branch of the Association plans to hold three meetings during the year.

• To stimulate a movement for the better protection of mothers and newborn infants, the Bureau of Child Hygiene of the Connecticut State Department of Health with the assistance of the Bureau of Public Health Nursing has planned three two-day maternity institutes for public health nurses—including those in schools and industry—and other nurses in that state. The Maternity Center Association of New York, N. Y. has made arrangements for Anita Jones, the assistant director, to present the essentials of maternity care at each of the institutes. These insti-

tutes aim to bring new and important factors regarding maternal care into discussion so that public health nurses may be better prepared when they assist mothers in meeting the problems of this momentous period in their lives.

• The week-end of January 23-25 has been designated Child Labor Day by the National Child Labor Committee. The purpose of the Child Labor Day is to arouse interest in the needs of the working child and to stimulate efforts to correct the appalling child labor conditions which still exist in many sections of the United States. Information and literature may be obtained from the Committee, 419 Fourth Avenue, New York, N. Y.

• Plans for the first National Social Hygiene Day, to be held February 3, 1937, are announced by the American Social Hygiene Association, 50 West 50th Street, New York, N. Y. On this day, state and community voluntary organizations interested in the control of syphilis and gonorrhea and other social hygiene problems are planning—with the advice and approval of health authorities and the medical and allied professions—to hold meetings all over the United States.

In New York City, the annual meeting of the American Social Hygiene Association will be held on that day as will also the Fifth Annual Regional Conference of the Social Hygiene Council of Greater New York. It is expected that public leaders, including Surgeon General Thomas Parran and President Ray Lyman Wilbur of Stanford University, President of the American Social Hygiene Association, will speak at these meetings. National agencies and many of their state and community organizations which include social hygiene activities in their yearly programs are planning to participate. It is probable that a nation-wide radio hook-up will provide addresses of great importance from high government officials and civic leaders in different parts of the country.

Further announcements will appear in the *Social Hygiene News*, the *Journal of Social Hygiene* and newspapers throughout the country.

• A group of men and women from many sections of the country met in New York City on November 20 to pay tribute to Mrs. Mary Willcox Glenn who is retiring from the presidency of the Family Welfare Association of America after sixteen years in this position of leadership.

• Alumnæ and former officials of the Army School of Nursing will be glad to know that Lulu K. Wolf, announced last month as the winner of an annual scholarship for study in London under the Florence Nightingale International Foundation, is a graduate of the Army School of Nursing, Class of 1924.

NEW APPOINTMENTS

(For J.V.S. Appointments see page 52)

Mary Mulvany, Supervisor, Child Hygiene Division, City Department of Health, Providence, R. I. (Appointment effective January 1, 1937).

Florence C. Morrow, Health Worker, Public Schools, Solano County, Calif.

Mrs. Ruth Huddleston, District Supervising Nurse, State Division of Public Health, Denver, Colo.

Genevieve Lill, Nurse in Health Service, State University, Missoula, Mont.

Catherine Nichols, School Nurse, Belchertown, Danna, Enfield, Greenwich, Mass.

Hazel Kandler, School Nurse, Camden, N. Y.

Ruth Clayton, Ingersoll Rand Company, New York, N. Y.

Maida A. Smith, County Nurse, Catron County (State Department of Health), Santa Fe, N. M.

Margaret Stevens, County Nurse, Coffee County, Ala.

Helen B. Lovell, Community Nurse, American Red Cross Nursing Service, Annapolis, Md.

Madeleine Buck and Evelyn Ward, County Nurses, Weld County Chapter American Red Cross, Greeley, Colo.

Ruby P. Caron, Staff Nurse, Visiting Nurse Association, Brooklyn, N. Y.

CORRECTION: Grace Frauens is the newly appointed Director of the St. Joseph Organization for Public Health Nursing, St. Joseph, Missouri, and not of the Visiting Nurse Association in Kansas City, Missouri, as was announced last month.

Study Page for January

Suggestions for Board Members, Executives, Staff Nurses, and Students

The following questions are based on the published material in this number, and offer suggestions for the use of the magazine:

Board Members

How does the National Organization for Public Health Nursing serve you? What are some of the problems with which it can give you help? ***Study Program for Board and Committee Members.*** Page 32.

What part does the public health nurse play in a program for crippled children? *Public Health Nursing in Programs for Crippled Children.* Page 10.

What are some of the steps to be taken in bringing about an amalgamation of the nursing services in a community? ***Amalgamation of Services in Minneapolis.*** Page 26.

What is the contribution of the public health nurse in the control of syphilis and gonorrhea? ***The Public Health Nurse in the Control of Syphilis and Gonorrhea.*** Page 5.

Executives and Supervisors

How can an agency evaluate its own service? Some suggested questions to be used as a guide in self-study are given in a New Year's editorial. *Through the Microscope.* Page 1.

How can the public health nurse participate in the program for the control of syphilis and gonorrhea? See question 4 under Board Members.

What are some essential conditions of a staff education program? ***A Staff Education Program Is Born.*** Page 3.

What are some important considerations that arise in an amalgamation of nursing services? See question 3 under Board Members.

Staff Nurses

What preparation does an industrial nurse need for her job? ***Industrial Nursing Pays,*** page 36, and *Preparation of the Nurse in Industry,* page 3.

What are the functions of the nurse and teacher in an eye health program? ***A School Program for Eye Health—Physical Aspects.*** Page 56.

Can you answer the maternity questions on page 48. Try scoring yourself on them, and then look up the ones you cannot answer. *How Would You Answer These?* Page 48.

What part does the public health nurse take in the program for the control of syphilis and gonorrhea? See question 4 under Board Members.

What are some of the emotional problems which may occur during pregnancy, and with which the nurse should be familiar? ***Maternity and Mental Hygiene.*** Page 16.

Student Nurses

What does the nurse need to know about eye health? See question 2 under Staff Nurses.

What are some factors contributing to reading deficiency in children? ***Factors in Reading Deficiency.*** Page 29.

How Would You Answer These—questions which the maternity nurse should know? Page 48.

Official Directory of Public Health Nurses

Listing those holding executive positions in the Government and in states, and officers of state organizations for public health nursing and public health nursing sections of state nurses' associations

Information as of December 1, 1936, unless otherwise stated.

The National Organization for Public Health Nursing, Inc.

President, Amelia Grant, Department of Health, New York, N. Y. General Director, Dorothy Deming, 50 W. 50th St., New York, N. Y.

American Red Cross, Nursing Service

National Director, Ida F. Butler, American Red Cross, Washington, D. C.

Public Health Nursing and Home Hygiene and Care of the Sick Service

National Director, I. Malinde Havey, American Red Cross Headquarters, Washington, D. C.

Eastern Area

(All to be addressed at American Red Cross Headquarters, Washington, D. C.)

Assistants to the National Director:

Margaret E. Dizney
Charlotte M. Heilman
Annabelle Petersen—Florida, Georgia, Indiana, Ohio, Virginia, West Virginia.
Eugenia Klinefelter—Alabama, Kentucky, Louisiana, Massachusetts, Mississippi, North Carolina, Rhode Island, South Carolina, Tennessee.
Marie Peterson—Connecticut, New Hampshire, New York, Maine, Vermont.
Mary DeLaskey—Delaware, District of Columbia, Maryland, New Jersey, Pennsylvania.

Nursing Field Representatives:

Gladyce Badger—New Jersey, New York.
Miriam A. Dailey—Indiana, Ohio, Virginia, West Virginia.
Alice Dugger—Alabama, Florida, Georgia, North Carolina, South Carolina.
Zella Bryant—Kentucky, Louisiana, Mississippi, Tennessee.
Elizabeth Hill—Delaware, District of Columbia, Maryland, Pennsylvania.
Laura Knowlton—Maine, New Hampshire (Resigning December 31, 1936).
Katherine R. Murphy—Massachusetts, Rhode Island, Vermont.
Elizabeth Taylor—Connecticut.

Midwestern Area

(All to be addressed at American Red Cross, 1709 Washington Avenue, St. Louis, Mo.)

Director, Mrs. Elsbeth H. Vaughan.
Assistants to the Director:
Lona L. Trott.
Ella Gimmestad.
Nursing Field Representatives:
Theresa Campbell, Supervisor, Visiting Nurse Services and General Nursing Work in Oklahoma, Missouri, Arkansas.
Thora Ingebritson—Colorado, Kansas, Nebraska, New Mexico, Texas.
Martha Bredemeier—Iowa, Montana, North Dakota, South Dakota, Wyoming.
Rebecca Pond—Illinois, Michigan, Minnesota, Wisconsin.

Pacific Area

(All to be addressed at American Red Cross, Civic Auditorium, Larkin and Grove Sts., San Francisco, Calif.)

Assistant Director, Calista L. Crown—Arizona, California, Nevada.
Nursing Field Representative, Myrtis Coltharp—Idaho, Oregon, Utah, Washington.

U. S. Department of the Interior

Bureau of Indian Affairs—Director of Nursing, Elinor D. Gregg, Office of Indian Affairs, Department of the Interior, Washington, D. C.

U. S. Department of Labor

Children's Bureau, Public Health Nursing Unit—Director of Public Health Nursing, Naomi Deutsch, Children's Bureau, Department of Labor, Washington, D. C.

Regional Public Health Nursing Consultants and Territory

(To be addressed at Children's Bureau, Department of Labor, Washington, D. C.)

Hortense Hilbert—Maine, New Hampshire, Vermont, Massachusetts, New York, Connecticut, Rhode Island, Pennsylvania, New Jersey, District of Columbia.
Ruth Heintzelman—Maryland, Delaware, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida.
Jane Nicholson—Illinois, Indiana, Ohio, Iowa, Michigan, Minnesota, Wisconsin, North Dakota, South Dakota, Nebraska, Kansas, Missouri.
Ruth Cushman, Room 1048 Canal Bank Bldg., 210 Baronne St., New Orleans, La.—Kentucky, Tennessee, Alabama, Louisiana, Arkansas, Mississippi, Oklahoma, Texas.
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U. S. Department of the Navy

Navy Nurse Corps—Superintendent, Myn M. Hoffman, 1802 Navy Dept., Washington, D. C.

U. S. Department of the Treasury

Bureau of the Public Health Service—Superintendent of Nurses, Katharine S. Read, Office of the Surgeon General, U. S. Public Health Service, Washington, D. C.

Bureau of the Public Health Service, Public Health Nursing Service—Pearl McIver, Senior Public Health Nursing Consultant.

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U. S. Department of War

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U. S. Veterans' Administration

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State Board of Health—Florence Stein, Chief Nursing Consultant. Division of Maternal and Child Health, Mrs. Jennette H. Banker, Educational and Child Hygiene Nurse.

ARKANSAS

State Organization for Public Health Nursing—President, Octavia Lowrey, Fayetteville. Vice-President, Agnes McCall, 1901 Taylor Ave., Little Rock. Sec., Lila Russell, Clarksville. Treas., Ruby Odenbaugh, Louisville.

State Board of Health—Margaret S. Vaughan, Supervisor, Public Health Nursing, Little Rock.

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MINNESOTA

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State Board of Health, Child Hygiene and Public Health Nursing—Mary D. Osborne, Associate Director, Jackson.

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Section on Public Health Nursing of State Nurses' Association—Chairman, Mrs. Zepherine Hosham, Claremont. Vice-Chairman, Hazel Bryant, Littleton. Sec., Velma V. Pehiner, District Nursing Association, Portsmouth.
State Department of Health, Division of Maternity, Infancy and Child Hygiene—Mrs. Mary D. Davis, Director, Public Health Nursing, State House, Concord.
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NEW JERSEY

State Organization for Public Health Nursing—Pres., Hettie W. Seifert, 1301 Union Court House, Elizabeth. Sec., Evelyn T. Walker, 131 Pearl St., Red Bank. Treas., Grace Remshard, State House, Trenton. Chairman Membership Committee, Mrs. Mary Nevin, 270 Orchard Terrace, Bogota.
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NEW YORK

State Organization for Public Health Nursing—Pres., Jean M. Henry, Hotel Wellington, Albany. Sec., Florence Manley, 65 Court St., Buffalo. Treas., Bertice A. Rees, 65 Court St., Buffalo. Chairman Membership Committee, Ellen Buell, Syracuse University, Syracuse.
State Department of Health, Division of Public Health Nursing—Marion W. Sheahan, Director, State Office Bldg., Albany.
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State Nurses' Association Paid Executive—Emily J. Hicks, 152 Washington Ave., Albany.

NORTH CAROLINA

Section on Public Health Nursing of State Nurses' Association—Chairman, Edna McKee, Board of Health, Greenville. Vice-Chairman, Mabel Patton, State Board of Health, Raleigh. Sec., Mary Crockett, Board of Health, Greenville.
State Board of Health, Division of County Health Work—Josephine L. Daniel, Consultant in Public Health Nursing, Raleigh.

NORTH DAKOTA

Section on Public Health Nursing of State Nurses' Association—Chairman, Mabel Draxton, Wahpeton. Vice-Chairman, Olive Lee, Minot. Sec., Florence Porter, Devils Lake.
State Department of Health, Division of Child Hygiene and Public Health Nursing—Marguerite Skaarup, Acting State Supervisor, Public Health Nursing, State Capitol, Bismarck.

OHIO

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OKLAHOMA

State Organization for Public Health Nursing—Pres., Mrs. Barbara Young, 312 W. Blackwell St., Blackwell. Sec., Eleanore Moore, 505 Ramsey Tower, Oklahoma City. Treas., Harriet Bookstore, 1200 E. 20th St., Oklahoma City. Chairman Membership Committee, Anna Picklum, 530 So. Reno St., El Reno.

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OREGON

State Organization for Public Health Nursing—Pres., Alyce Bloom, 305 Stevens Bldg., Portland. Sec., Hope A. Brady, 305 Stevens Bldg. Portland. Treas., Mary Cowell, 305 Stevens Bldg., Portland. Chairman Membership Committee, Olive Whitlock, 816 Oregon Bldg., Portland.

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Pennsylvania Tuberculosis Society, 311 So. Juniper St., Philadelphia—Frances H. Meyer.

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RHODE ISLAND

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State Nurses' Association Paid Executive—Nellie C. Cunningham, 309 Carolina Life Bldg., Columbia.

SOUTH DAKOTA

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State Board of Health—Mrs. Florence Walker Englesby, State Superintendent of Nurses, Pierre.

TENNESSEE

Section on Public Health Nursing of State Nurses' Association—Chairman, Bertha Greenwalt, State Health Department, Nashville. Vice-Chairman, Bertha Knipfer, Davidson County Health Department, Nashville. Sec., Ruth White, Bradley County Health Department, Cleveland.

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TEXAS

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UTAH

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VERMONT

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VIRGINIA

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WEST VIRGINIA

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State Department of Health—Mrs. Laurene C. Fisher, State Advisory Nurse, Charleston.

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WISCONSIN

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WYOMING

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City of Panama, Visiting Nurse Service—Louisa Kurath, Director, Departamento Nacional de Higiene y Salubridad Publica, Republic of Panama, Panama City.

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